Report to Congress by the

Competitive Pricing Advisory Committee of the

U. S. Department of Health and Human Services

January 19, 2001

Table of Contents

Chapter 1. Introduction to the Congressional Report, Including A Summary of Less Learned	1 3
Learned	1 3
 1.0 Introduction	1 3
 1.1 History of the Medicare Competitive Pricing Demonstrations, 1989 – 1999 1.1.1 Baltimore, 1996	3
1.1.1 Baltimore, 1996	
1.1.2 Denver, 1997	
1.1.3 The BBA-mandated demonstrations: Kansas City and Phoenix, 19991.2 General lessons of the Competitive Pricing Demonstration to date	
1.2 General lessons of the Competitive Pricing Demonstration to date	
1 / 1 Designing and implementing competitive pricing	
1.2.2 Education, communications, and building consensus	
1.2.3 Providing information critical to the Medicare reform discussion	
1.2.4 Solving what was, within the constraints of the demonstration, the ma	
problem with competitive pricing: political opposition	IIII 2∩
1.3 Conclusion	
1.5 001101031011	20
Chapter 2. Including Fee-for-Service Medicare in the Competitive Pricing Demonstr	ration 28
2.0 Introduction	
2.1 What does it mean to incorporate fee-for-service in the demonstration?	
2.2 Linking traditional FFS and M+C rates in the CPAC demonstration design:	
reimbursement caps and premium rebates	30
2.3 How to incorporate FFS more completely	31
2.3.1 The political challenge	32
2.3.2 How would FFS Medicare participate in a Competitive Pricing	
Demonstration?	
2.3.3 On what benefit package would FFS Medicare bid?	
2.3.4 How should the government's contribution to premiums and beneficial	
out-of-pocket premiums be determined?	
2.3.5 How "level" can the playing field be?	
2.4 Summary and possible changes in demonstration design	39
2.4.1 Ensure that the FFS bid is less than the government contribution to	
premiums	
2.4.2 Lump-sum payments to hold the <u>demonstration area</u> harmless	42
2.4.3 Lump-sum payments and a suspension of budget neutrality to hold	
beneficiaries harmless from financial impacts of the Demonstration	42
Chapter 2. The Nature and Extent of Oxidity Manitoring Activities	A E
Chapter 3. The Nature and Extent of Quality Monitoring Activities	
3.0 Introduction	
3.0 Introduction	45
Introduction	45
3.0 Introduction	45 46
3.0 Introduction	45 46 47
3.0 Introduction	454650 and
 3.0 Introduction	
 3.0 Introduction	
3.0 Introduction	
 3.0 Introduction	

Chapter 4.	A Rural Demonstration of Competitive Pricing in Medicare	. 58
4.0	Introduction	
4.1	Problems with the BBA mandate	. 59
	4.1.1 What is "rural"?	. 59
	4.1.2 What is the "problem" in rural areas?	. 59
	4.1.3 Can competitive pricing help?	
4.2	An achievable objective	
4.3	Implementation	. 62
	4.3.1 Altering the <u>level</u> of payment to M+C plans	
	4.3.2 Altering the structure of payments to M+C plans and FFS providers	
4.4	Summary	
Appe	ndix	. 70
	I Introduction and general market area characteristics	. 71
	Il Medicare managed care data	. 71
	III Medicaid managed care data	. 76
	IV Commercial managed care data	. 78
	A Commercial enrollment	. 78
	B Relationship between presence in an HMO service area and commercial	
	enrollment in counties with commercial data	. 79
	C Relationship between commercial and Medicaid managed care	
	enrollment in counties with commercial data	. 80
01 - 1 - 5	The Beautiful Otto at an	0.4
	The Benefit Structure	
5.0	Introduction	
5.1	CPAC and AAC decisions about the benefit package	
5.2	Requiring a standard benefit package of all plans	. 84
5.3	Expanding producer and consumer choice: unlimited supplements, benefit	~~
5 4	enhancements by low bidders, and mid-cycle corrections	. 86
5.4	CPAC action on alternatives to allow high-bidding plans to avoid charging	07
	a premium	
	5.4.1 Waiving nuisance premiums	
	5.4.2 Allowing high-bidders to take a reduction in reimbursement	. 88
	5.4.3 Allowing high-bidders to reduce elements of the standard	~~
	benefit	
5.5	Setting the level of the benefit	
5.6	The role of the AACs in setting the standard benefit package	
5.7	Benefit structure issues: summary and conclusion	. 95
Chapter 6	Recommendations	102
aptor o.		

Competitive Pricing Advisory Committee Report to Congress

Executive Summary

Medicare has provided capitated payments for managed care services since the mid-1980s. These capitated payments are *administrative prices*, based on calculations from Medicare's fee-for-service administrative records. These administrative prices have been criticized by virtually all serious observers from the beginning of the program. Competitive pricing is one promising alternative that – if it worked well – could set equitable and efficient prices. It could give beneficiaries the assurance of clearer plan choices, more adequate and more stable benefits, and improved quality. To confirm that it works well in the Medicare setting, a series of demonstrations have been attempted, first in Baltimore (1996), then Denver (1997), and most recently in Kansas City and Phoenix (1999). In each case, political opposition and Congressional intervention (in one case aided by judicial action) stopped these tests before they began.

The Kansas City and Phoenix tests had special legislative authority. Under the Balanced Budget Act of 1997 (BBA, Public Law 105-33, Section 4011), the Department of Health and Human Services (DHHS) was required to establish at least four (and up to seven) competitive pricing demonstration projects for Medicare+Choice (M+C) plans. At least one of the initial four projects was to be in a rural area. The BBA also required DHHS to set up a national Competitive Pricing Advisory Committee (CPAC) comprised of national experts and stakeholders. The CPAC was tasked to select the demonstration sites, to advise DHHS on the design of the demonstration, and to make recommendations on monitoring and evaluating the demonstration. Area Advisory Committees (AACs) composed of local interests in each site were to assist in implementing the CPAC design and adapting it to local circumstances. The demonstration was required under the BBA to be budget neutral in each site each year of the demonstration, an important constraint.

When Congress stopped the BBA demonstrations in 1999, it also required the CPAC to answer a series of questions about how the competitive pricing demonstration might best be done, concerning:

- (A) Incorporation of the original Medicare fee-for-service (FFS) program into the project.
- (B) The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, especially in comparison to traditional Medicare fee-for-service (FFS).
- (C) The challenge of initiating a project site in a rural area, and recommendations on how the project might best be changed so that such a site is viable.

(D) The nature and extent of the benefit structure in the project, especially in relation to questions of plan standardization and options to permit high-bidding plans to avoid charging a premium.

Implementation of the competitive pricing demonstration was not to occur until 6 months after the date the CPAC submitted the above reports to Congress and, in any event, no sooner than January 1, 2002. Thus, the CPAC must report to Congress on a series of issues that capture prominent concerns about whether and how to proceed with competitive pricing, before the demonstration can proceed. In this report, the CPAC sets forth its answers to the questions Congress has asked and provides some judgments about next steps.

History of the Medicare Competitive Pricing Demonstrations, 1989 – 1999

In 1989, HCFA began a series of studies that led to four demonstration attempts in the second half of the 1990s. Each of the four attempts was thwarted:

- Baltimore and Denver demonstrations were both stopped by Congress after health plans objections. Health plans and state officials objected to:
 - The risk of being a high bidder and having to charge an out-of-pocket premium to beneficiaries.
 - HCFA's discretion in setting the "cutoff price" according to its own judgment, after inspecting the bids, rather than according to a fixed rule announced in advance.
 - HCFA's proposal to use a third-party enrollment contractor, rather than having beneficiaries enroll directly with the plans.
 - Possible conflicts with state systems and projects (in Baltimore only).
 - Disrupting the market at a critical time and dangers of "low ball" bids (Denver only).
 - The exclusion of FFS from the demonstration (the lack of a "level playing field"), as HMOs would be subject to competitive pressures but FFS reimbursement would not.
- The BBA demonstrations were designed by the CPAC in a series of national meetings. The CPAC design for the demonstration (as later modified and adapted by the AACs) appears in Exhibit ES.1 below.
- CPAC's site selections were binding on DHHS, under the BBA. CPAC selected the Kansas City and Phoenix sites by narrowing a list of 319 metropolitan areas in the U.S. through a structured series of analyses of quantitative and (as the list of sites was reduced) qualitative indicators of site characteristics. The committee generally focused on sites with relatively high payment rates. Low payment sites might have been more receptive to the demonstration. But they could not be considered, given the budget neutrality requirements of the BBA.

Exhibit ES.1. The Demonstration Design Formulated By The Competitive Pricing Advisory Committee: Summary

I. ELIGIBILITY AND PARTICIPATION

1 - Plan Eligibility

All Medicare+Choice plans in the demonstration area are required to participate in the demonstration. Only Medical Savings Accounts (MSAs) are exempt.

Medicare fee-for-service is not included in the demonstration as a bidding plan, but does face potential price competition with M+C plans (through the premium rebates that low bidding plans can choose to offer).

To participate in the demonstration, M+C plans must follow standard Medicare practice – i.e., there is no waiver of the conditions that plans normally must satisfy to participate in Medicare.

Interested, but not yet qualified, plans can participate in the bidding. But such plans must fully qualify before the bids take effect, in order to participate.

2 - Plan Participation

Participation is mandatory for all eligible plans – i.e., all M+C plans except MSAs. However, M+C plans that decide not to participate will not be penalized. If still eligible to participate under terms described above, non-participating plans in one year can enter the bidding in a subsequent year, without penalty.

Plans in the demonstration area that are participating in other HCFA demonstration projects will be exempted from the Competitive Pricing Demonstration on a case-by-case basis.

3 - Participation by Medigap Insurers

Medigap insurers are not required to participate in the demonstration (e.g., they are not required to coordinate benefits with the Competitive Pricing Demonstration).

Beneficiaries should be given information about Medigap plans, as part of the special demonstration efforts to inform beneficiaries.

4 - Employer Role

Employers are not required to participate in the demonstration. Medicare reimbursement in the demonstration area will be determined by the Competitive Pricing Demonstration, but employers are allowed to continue to offer different benefit packages to their group beneficiaries, even if those packages are less generous than the demonstration package.

II. THE BENEFIT PACKAGE

5 - Standard Benefit Package?

All plans must bid on the same package of basic benefits.

The standard benefit package will be the <u>highest</u> of the following:

- the statutory entitlement
- a national minimum standard package composed of the statutory benefit plus an outpatient prescription drug benefit (\$500 cap with cost sharing)
- . the expected norm in the market in the absence of the demonstration.

6 - Optional Supplementary Benefits

Optional supplements can be offered only as additions to the basic benefit.

There is otherwise no limitation on the number or type of optional supplements. But HCFA should standardize the language used to describe these benefits.

7 - Mid-Cycle Adjustments to Benefits

Plans are allowed to enhance their benefit packages 6 months (half-way) through the bidding cycle.

Exhibit ES.1. SUMMARY OF THE DEMONSTRATION DESIGN [continued]

III. THE BIDDING PROCESS

8 - The Bidding Cycle

The bidding cycle is one year. The bidding schedule should match the Medicare+Choice schedule insofar as possible.

9 - PRE-BID: Discussions between HCFA and Plans

Before the solicitation is issued: The bidding process should utilize the AACs: (a) to advise on the bidding process/other implementation issues, and (b) to coordinate education activities on bidding and, in particular, risk adjustment. Educational sessions should be held to provide technical assistance to plans. Pre-bid conferences should be open to all plans, but there should be no private conferences with particular plans.

After the solicitation is issued: HCFA should: (a) accept formal written questions and provide written answers to all bidders; and (b) hold a Bidder's Conference and provide written answers (distributed to all bidders) for any questions raised by bidders after the solicitation is issued. There should be no private or informal discussions with particular plans.

10 - POST-BID: The Process for Reaching Agreement

HCFA should determine the results of bidding from formal bids, rather than negotiations, in a first round of bidding. But HCFA should reserve the right to request a second round of bids, if the first-round bids are unacceptable.

11 - The Structure of the Bid

The general rule is to require less, rather than more, information. Plans should not be required to provide detailed pricing breakdowns, unless the CPAC determines that such information is necessary to achieve the purposes of the demonstration (e.g., to support the evaluation).

Bids should apply only to the demonstration area, but plans are not required to serve the entire demonstration area.

Plans should submit bids on one base county, with payments in other counties adjusted according to the ratios of current M+C payment rates.

IV.THE GOVERNMENT CONTRIBUTION TO PREMIUMS

12 - Setting the Contribution

The cutoff price or the base government contribution to premiums should be set at the *higher* of: a) the median bid (adjusted to reflect available capacity in low bid plans); or (2) the enrollment-weighted average bid (based on the prior year's Medicare+Choice enrollment).

13 - What are the incentives to bid low for high- and low-bidding plans?

<u>Plans bidding above the government contribution or cutoff price</u>: The excess of plan bids over the cutoff price should be converted to a beneficiary out-of-pocket premium.

<u>Plans bidding below the government contribution or cutoff price</u>: All low-bidding plans should be paid at the cutoff rate and allowed to: a) retain the difference, b) rebate the difference to beneficiaries in cash (up to the amount of the Part B premium), c) add benefits worth the difference, or d) some equivalent combination of these three options.

14 - Risk Adjustment

Health plans should submit bids on a baseline "1.0" beneficiary. HCFA should use then-current Medicare risk adjustment methods to compute payments, unless the local AAC chooses either: 1) to delay risk adjustment and keep the old (demographic-based) risk adjustment in year one of the demonstration, with new HCFA method of risk adjustment methods implemented thereafter [note that this provision has been rendered obsolete by recent delays in the demonstration]; or 2) alternatives proposed in a timely way by the AAC for the chronically ill or other sub-populations, so long as HCFA can administer them.

Beneficiary out-of-pocket premiums should not be risk adjusted – for each plan, enrollees in all risk categories should pay the same premium.

15 - Taking Quality into Account

In the early years of the demonstration, quality assurance should follow current Medicare practices – i.e., rely on the plan qualification process and retail competition among plans (and consider using existing accreditation agencies such as NCQA or JCAHO) to ensure the quality of care of health plans.

In later years of the demonstration, the creation of quality incentive pools should be considered.

• Opposition in Kansas City and, especially, Phoenix led to Congressional opposition to proceeding with the demonstration. In November 1999, the Consolidated Appropriations Act of 2000 stopped appropriations to implement the Kansas City and Phoenix demonstrations.

Given this history of thwarted attempts, it will be useful to consider: (a) the lessons learned from this effort thus far, (b) some of the difficulties that have impeded these efforts to date, and (c) revised approaches that might give future efforts a better chance of success.

Lessons learned

The experience of attempting to design and implement a Competitive Pricing Demonstration has revealed a series of lessons, in the CPAC's view. These lessons are detailed in the report and suggest four major themes. First, perhaps the most important lesson of all is the most basic: CPAC was able to carry out its Congressional mandate with deliberation and dispatch, within the constraints of federal regulations. It was indeed possible to set up a committee of diverse national experts independent of DHHS to bring key stakeholder perspectives to bear on the major decisions concerning demonstration design, site selection, and implementation.

Second, the Competitive Pricing Demonstration – as far as it has gone – has shown competitive pricing to be a practical approach for Medicare to consider. For example, the decisions involved (e.g., to standardize benefits) appear amenable to reasonable solutions even amidst political conflict. The administrative challenges of running a bidding process with extensive stakeholder input have proved to be tractable.

Third, however, some apparent requirements of competitive pricing have not been readily resolved to date – specifically, the need for effective education, communication, and consensus-building to address at times intense political conflict. In particular, HCFA faces certain legal and other limits in this area, and the CPAC is not constituted or chartered for that role. The more active engagement of Congress would be desirable to create and maintain a basis of political support for this venture.

Finally, a related point, the demonstration efforts in Baltimore, Denver, Kansas City, and Phoenix have made it clear that the key impediments to competitive pricing are not conceptual or practical, but rather political, given the constraints of the demonstration. The political opposition is grounded in perceived economic self-interest. The successful implementation of competitive pricing will require the successful resolution of those political problems. Competitive pricing for M+C plans will always have opponents, but it needs more support than it has had to date, if it is to go forward. To secure that support, it will be essential to fashion more creative approaches to demonstration design, approaches that promise a vigorous competitive process but also provide the means to enhance demonstration support. One way to do that will be to give CPAC more flexible tools to revise the demonstration design, site selection, and implementation.

January 19, 2001 Page viii

These general lessons provide a useful background for considering the more specific questions Congress has asked the committee. Each of the four main chapters of the report is devoted to one of the issue areas raised by Congress, beginning in Chapter 2 with Congressional questions concerning the inclusion of fee-for-service in the demonstration.

Incorporating Medicare fee-for-service in the demonstration

There are compelling legal constraints and political difficulties that argue against complete inclusion of FFS Medicare in a demonstration of competitive pricing, at the initial sites and in the initial years of the demonstration. But the incorporation of FFS is not an all or nothing decision along a single design dimension. For example, while the CPAC demonstration design did not include FFS as a bidding health plan, it established an important link between M+C and FFS prices: premium rebates. (This option was added to the demonstration design late in the design phase of the project.) Premium rebates were a way to create direct price competition between M+C plans and FFS in the demonstration.

While the demonstration CPAC designed did not fully incorporate FFS, the question remains of how FFS might be included more completely in later sites and years of the demonstration. There are a series of important issues to consider. First, how can the demonstration overcome political opposition, with the more complete inclusion of FFS? The more complete inclusion of FFS would create a new group of opponents: FFS beneficiaries facing the risk of higher premiums. This could be a crippling difficulty in a demonstration thwarted to date by political opposition. Second, exactly how would FFS Medicare participate in a Competitive Pricing Demonstration? In order to include FFS Medicare in a demonstration, some arrangement must be made for FFS Medicare to act like a competing bidder. In this respect (as in many others), the inclusion of FFS represents a major challenge in its own right. Third, on what benefit package should FFS Medicare bid? FFS Medicare is based strictly on the entitlement, not the enhanced M+C package specified by CPAC for the M+C-only demonstration. CPAC concluded that, if FFS were included as a bidding health plan, the only practical option was to allow different FFS and M+C benefit packages, and perform analytic adjustments to make the two sets of bids roughly comparable. Fourth, how should the government's contribution to premiums and the out-ofpocket premiums of beneficiaries be set? This question arises because FFS is the largest plan in most sites, which means that the contribution rule (higher of the enrollment-weighted average or median of bids) would have very different results once FFS is included as a competing bidder. The key issues in this area revolve around whether and how to subsidize the most expensive plan (usually FFS), as is often done in commercial and other public programs. Finally, how level can the playing field between FFS and M+C be? Leveling the playing field between FFS Medicare and M+C plans is not feasible in a demonstration. FFS and M+C plans operate under different constraints, and a demonstration should take those differences into account when comparing bids, but not attempt to eliminate those differences, especially for the brief period of a demonstration.

The above problems argue for postponing the complete inclusion of FFS until after the initial years and initial sites of the demonstration. But the question remains as to what

can be done to facilitate more complete inclusion of FFS in the future. The CPAC can offer some suggestions that might ease this process, although there are no easy answers. The most promising suggestions on this score are to provide lump-sum payments to sites or beneficiaries to hold them harmless from the effects of the demonstration. This kind of payment would require suspension of the budget neutrality requirements of the demonstration, i.e., bringing additional funds to demonstration areas. It would recognize that the demonstration is important to the future of Medicare, and beneficiaries should be compensated to offset any financial harm they might suffer by being selected as subjects for such a test.

The nature and extent of quality monitoring activities

From the first meeting of the CPAC, the committee made clear that it wanted to consider ways to use quality reporting as a key management tool: i.e., to join the incentives of competitive pricing to measures of quality, so that the demonstration could address issues of health care value, not just the level of Medicare prices. The committee concluded after a series of briefings from innovative health care programs and from quality experts at HCFA that:

- Quality reporting by M+C plans in the demonstration should be the same as the reporting requirements these plans ordinarily face.
- Quality innovations under consideration notably, the use of quality incentive pools as part of the payment system – should be based on measures of quality already being collected.

CPAC wanted to minimize additional reporting burdens on demonstration health plans, given all the other things being asked of them. The only additional quality monitoring efforts envisioned for the demonstration were to be undertaken by HCFA at its expense, not by M+C plans.

Congress has asked CPAC to report on HCFA's current ability to support FFS reporting activities comparable to M+C reporting activities. FFS monitoring and reporting requirements typically are less burdensome than the monitoring and reporting requirements imposed on M+C plans. But efforts are under way to increase the reporting and interpreting of quality measures from FFS providers. Although HCFA has been overseeing a set of new analytic efforts to adapt quality performance measures (e.g., HEDIS) to the FFS setting, these efforts have certain intrinsic limits. By comparison to M+C organizations, FFS providers have less control over beneficiary health status, have patient groups that are not so clearly defined, have less capable information systems, face structural barriers to combining information across practice or service settings, and may have different kinds of patients, with different health-seeking behaviors that influence the rate of preventive service performance in FFS. More research is required to understand these problems, a task outside the scope of the Competitive Pricing Demonstration.

Differences in reporting requirements between FFS and M+C plans may have to narrow if FFS is to be incorporated into the Competitive Pricing Demonstration (as discussed in Chapter 2). The timing required to narrow these differences might not coincide with the timeframe of the demonstration initiative. Meanwhile, although the added burden on M+C plans for quality reporting and monitoring was not to be increased by the demonstration, the demonstration was going to receive special data collection and monitoring efforts funded and implemented by HCFA. In other words, in a small demonstration area, HCFA could devote extra efforts to the review and analysis of existing data – and to the acquisition of additional information – with no additional burden on the plans.

The challenge of a rural demonstration of competitive pricing in Medicare

The BBA specifies that at least one of the initial demonstration sites shall be a "rural" area. CPAC has given considerable thought to a rural demonstration project and foresees a number of important challenges. During the site selection process, the CPAC emphasized choice of a site in a non-rural area. Recognizing the complications associated with rural site selection, the CPAC decided to defer selection of a rural site until after the first two sites were chosen.

CPAC realized that health care in rural areas faces many challenges, and not all of those challenges can be met by government policy. However, CPAC remains interested in exploring the possibility that the primary policy "levers" at its disposal – the level and structure of payment to M+C plans and FFS providers – could lead to improvements in the health care delivery system in rural areas. CPAC concluded that it was a mistake to force M+C plans to serve counties they currently are not well equipped to serve. CPAC also realized that if M+C plans were willing and able to serve specific counties at current payment levels they already would be doing so. If it is deemed desirable to encourage M+C plans to expand their service areas, it will be necessary to determine the payment level that is adequate to support that expansion. One approach, the status quo, is to allow payments levels in low-payment counties to increase (in the manner provided through global administrative formulae of current policy under the BBA and the BBA Refinement Act) until plans are coaxed into serving those counties. Another, quicker, method is to have plans submit bids that reflect their estimated costs *now* of adequately serving a target rural county. Those bids would have to be disciplined by some process. Giving a "one-winner" contract to the lowest-priced qualified M+C plan is one option. Another option is to allow multiple winners and use the same incentive as CPAC's "urban" model (i.e., higher out-of-pocket premiums) to discipline bids in rural counties.

It is unlikely that the "one-winner" approach alone will lead to a successful demonstration of competitive pricing in a rural county. M+C plans face too many additional obstacles in rural counties for this incentive – sole provider status in a rural county – to elicit substantial changes. In order to justify the level of private investment necessary to develop provider contracts and offer a benefit package that competes successfully with FFS Medicare, it is likely that payment levels in a rural demonstration site will have to increase

beyond those specified in the 1997 BBA legislation. Those increases will require a waiver of the budget neutrality constraint. A final option is to try to partner with state Medicaid programs to attach a competitive pricing demonstration for Medicare to an existing network of Medicaid managed care in rural areas – an approach that would take advantage of certain economies of scale but present unique administrative challenges.

CPAC therefore concludes that, in order to proceed with a rural demonstration project, CPAC must have the flexibility to experiment with a number of different demonstration designs. The BBA already gives CPAC the waiver authority needed to work flexibly in resolving foreseeable administrative problems as might, for example, accompany an effort to mesh M+C coverage with existing Medicaid networks. But new legislative authority is likely to be necessary in other areas, to allow the award of a single M+C contract for some counties, and to waive the existing budget neutrality constraint that applies to the demonstration.

The benefit structure

With respect to the benefit issues raised by Congress, CPAC sees legitimate room for disagreement, but reached the following conclusions:

Standardized benefit package – On balance, the competitive process should be based on a standard benefit package – to facilitate comparison of bids by HCFA, to facilitate comparison of benefits by beneficiaries, to simplify administration (important if the demonstration was to be generalized), and to reduce the potential for risk selection. Further, the committee concludes that the benefit should be set at enhanced levels that constitute the market norm for the demonstration areas, to reduce the risk of beneficiary disruption. In any event, a minimum benefit (including \$500 outpatient prescription drug coverage) should be required.

Efforts to moderate the constraint of a standardized benefit – After the government contribution to premiums is set for the core benefit package and all core and supplemental packages are settled, it is possible to find ways to enhance producer and consumer choice and moderate the constraint of a standard benefit – by allowing unlimited supplementary benefits, by giving low bidders the option to offer benefit enhancements or premium rebates, by giving all plans the option to make mid-cycle enhancements in their benefits, and by allowing cafeteria benefits (a Phoenix proposal that 1 percent of the bid be devoted to any additional benefit the plan chooses, thereby allowing some additional plan discretion in the overall package without undermining the bidding process).

Ways to avoid premiums or enhance competition – CPAC fully supports granting low-bidding plans the option to offer premium rebates up to the level of the Part B premium amount, as a way to enhance competition (including competition with FFS) and to make the demonstration more attractive to beneficiaries. The committee also approved the AAC suggestion to streamline the premium collection requirements, so that only fairly substantial premiums (>\$10 per month) are collected.

However, CPAC believes it important to avoid changes in the benefit package that promise to undermine competition at the bidding stage. Thus, the committee has consistently rejected the Denver option of allowing plans to waive premiums in return for a payment penalty. The committee also opposes allowing high-bidding plans to offer benefit reductions (e.g., a higher percentage of out-of-pocket costs) in return for a reduction of the out-of-pocket premium. This option would increase the diversity of benefits available to consumers, but it would be a threat to the basic competitiveness of the bidding, as it would: a) reduce incentives for plans to bid low, b) introduce much greater administrative complexity into the bidding process by reducing the comparability of bids, c) make it much harder for consumers to compare plan benefits, and d) introduce serious threats of risk selection.

In order to make some of the difficult choices needed to specify a standard benefit – especially in a demonstration, at a time when there is no Medicare experience with this process – CPAC delegated discretion within defined parameters to the AACs. The effectiveness of this choice is reflected in the fact that both AACs succeeded in specifying standard benefits that took into account local concerns.

Recommendations

After weighing the experience of the Competitive Pricing Demonstration to date, the purposes that the demonstration was designed to serve, and the issues raised by Congress in the 1999 Balanced Budget Refinement Act and addressed by the CPAC in the report chapters above, CPAC concludes the following:

- 1. A Competitive Pricing Demonstration designed by CPAC should go forward, but only if budget neutrality is suspended. Congress should give CPAC the flexibility needed to devise creative solutions to the problems that competitive pricing presents.
- 2. The design and implementation of the Competitive Pricing Demonstration should continue to be done using the consultative arrangements established by Congress in the BBA. However, in these future efforts, the CPAC and AACs should have means available to consult with and better understand the concerns of Congress.
- 3. If Congress would like FFS included in the demonstration, it should give CPAC explicit authority to do so.
- 4. The demonstration needs more enduring political support from Congress.
- 5. Competitive pricing may offer some unique advantages for bringing M+C plans to rural areas, but to do so would require budget flexibility and the need to experiment with different demonstration designs than are applied in urban areas.

January 19, 2001 Page xiii

- 6. CPAC and the AACs should continue to develop quality incentive arrangements.
- 7. The Competitive Pricing Demonstration should continue to be based on a standard benefit package. CPAC should continue to explore ways to moderate the effects of that constraint, in ways that do not undermine the competitive bidding process.

Competitive Pricing Advisory Committee Report to Congress

Chapter 1.

Introduction to the Congressional Report, including A Summary of Lessons Learned

1.0 Introduction

Competitive pricing is a relatively simple idea that – if it worked well – could give Medicare confidence that the prices it sets for managed care services are equitable and efficient. It could give beneficiaries the assurance of clearer plan choices, more adequate and more stable benefits, and improved quality. To confirm that it works well in the Medicare setting, there have been a series of efforts to test competitive pricing in demonstration sites. Unfortunately, these efforts have generated intense conflict and controversy, with little to show so far in changes to Medicare's methods for setting capitated payments. That complicated experience is at the center of this report.

Medicare has provided capitated payments for managed care services since the mid-1980s. These payments are administrative prices, based on calculations from Medicare's fee-for-service administrative records. These administrative prices have been criticized by virtually all serious observers from the beginning. For over 10 years, acting on its own demonstration authority and (most recently) on a mandate from Congress, the Health Care Financing Administration (HCFA) has researched and attempted to set up tests of competitive pricing – procedures to elicit market-like prices – to replace administrative pricing methods. First in Baltimore (1996), then Denver (1997), and most recently in Kansas City and Phoenix (1999), Medicare has been stopped from proceeding with demonstrations of competitive pricing. In each case, political opposition and Congressional intervention (in one case aided by judicial action) stopped these tests before they began.

The Kansas City and Phoenix tests were not simply the last in a string of thwarted attempts. These tests had special authority. In 1997, Congress mandated a test of competitive pricing in the Balanced Budget Act of 1997 (BBA, Public Law 105-33, Section 4011). Under the BBA, the Department of Health and Human Services (DHHS) was required to establish at least four (and up to seven) competitive pricing demonstration projects for Medicare+Choice (M+C) plans. At least one of the initial four projects was to be in a rural area. The legislation said little about what the precise design of the demonstration should be. But it did specify how the design should be developed. The BBA required DHHS to set up a national Competitive Pricing Advisory Committee (CPAC) comprised of national experts and stakeholders. The CPAC was tasked to select the demonstration sites, to advise DHHS on the design of the demonstration, and to make

recommendations on monitoring and evaluating the demonstration. Area Advisory Committees (AACs) composed of local interests in each site were to assist in implementing the CPAC design and adapting it to local circumstances. These provisions created mechanisms to make the choice of a demonstration design, the selection of sites, and the implementation of the demonstration sensitive to the interests of beneficiaries, the managed care industry, providers, and others. The fact that the BBA demonstrations were stopped – notwithstanding the explicit Congressional mandate for the effort and the participation by national and local stakeholders at each stage – suggests the need to think carefully about whether and how to continue this venture.

When Congress stopped the BBA demonstrations in the Consolidated Appropriations Act 2000, passed in November 1999 (Public Law 106-113), it at the same time required the CPAC to step back from the particulars of the Kansas City and Phoenix demonstrations to answer a series of questions about how the competitive pricing demonstration might best be done. Specifically, the CPAC was required to submit a report to Congress on each of the following topics:¹

- (A) Incorporation of the original Medicare fee-for-service program into the project: What changes would be required in the project to feasibly incorporate the original Medicare fee-for-service program into the project in the areas in which the project is operational.
- (B) Quality activities: The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original Medicare fee-for-service program generally.
- (C) Rural project: The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project... and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.
- (D) Benefit structure: The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original Medicare fee-for-service program) to require Medicare

January 19, 2001 Page 2

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¹ These requirements are contained in Section 533 of H.R. 3426 (the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, hereinafter the BBA Refinement Act of 1999), which was enacted into law under the Consolidated Appropriations Act 2000. The language above follows the language of the statutory provision.

supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

Implementation of the competitive pricing demonstration was not to occur until 6 months after the date the CPAC submitted the above reports to Congress and, in any event, no sooner than January 1, 2002.²

Thus, before HCFA proceeds with any competitive pricing implementation, the CPAC must report to Congress on a series of issues that capture prominent concerns about whether and how to proceed with competitive pricing. In the chapters to follow, CPAC sets forth its answers to the questions Congress has asked and provides some judgments about next steps.

The report is organized around four main chapters, each addressing one of the four major questions Congress has asked. Before beginning that discussion, however, the CPAC would like to provide some background on the Competitive Pricing Demonstration (Section 1.1) and to review the general lessons of design and implementation that have been learned to date (Section 1.2).

1.1 History of the Medicare Competitive Pricing Demonstrations, 1989 – 1999

The history of the competitive pricing demonstrations in Medicare begins with the administrative pricing system that competitive pricing was to replace. In the early 1980s, Congress established an administrative pricing system for the Medicare HMO program. Under that system, HCFA determined the amount that HMOs were to be paid, based on feefor-service claims data. Originally, the administrative prices were set at the average cost of similar fee-for-service beneficiaries in each county, discounted by 5 percent. The BBA (Section 4001) altered the direct link between managed care and fee for service payments. Under the BBA, payment levels that historically have been very low and very high are being compressed towards the national average. But even under BBA methods, payment calculations begin with Medicare's historical FFS costs in each market area. That, in turn, has meant that information about the true costs of care flows in the wrong direction under the current system: from the organization that knows little or nothing about the true costs of care (HCFA) to the organizations that know as much as possible about the true costs of care (the health plans). M+C payments are not informed by information about costs generated by the plans themselves. The prices that result do not reflect the underlying costs of services in an accurate way and create winning and losing counties across the country. In some

² The BBA originally specified a start date of January 1, 1999, for the first demonstration projects. Early in its deliberations, the CPAC concluded that that date could not practically be met (the first CPAC meeting was May 1998, leaving too little time for CPAC to design the demonstration and select sites, for DHHS to appoint the AACs, for the AACs to adapt the CPAC design to their local circumstances, and for a bidding process to be run – all in time for fall 1998 open enrollment in M+C plans under demonstration auspices). As a result, the committee moved the start date back to January 1, 2000. Later, based on requests from the Kansas City and Phoenix AACs to delay the demonstration, the CPAC moved the start date back to January 1, 2001. The most recent Congressional intervention thus means a delay of at least one additional year.

counties, substantial drug benefits are free, while in other counties health plans charge a premium for the Medicare entitlement with no drug benefit.

Competitive pricing reverses the current flow of information in setting M+C payment rates. Competitive pricing is designed to create a structure of bidding so that M+C plans have incentives to tell HCFA how much it costs to care for Medicare beneficiaries. Health plans enjoy rewards for low bids and suffer penalties for high bids. This reversal of information flows – and the replacement of benefit-based competition with price-based competition – distinguishes competitive pricing from the current administrative pricing system. Benefit-based competition makes it difficult for beneficiaries to compare plans and, within a framework of fixed administrative prices, results in the government buying inefficient benefits – benefits worth less to beneficiaries than they cost to produce.

Competitive pricing has been used extensively for the pricing of public and private health services across the country. It is a tested method, innovative here only in its being applied to Medicare, the largest single payer for health services in the country. But if competitive pricing is conceptually straightforward, the application of competitive pricing to Medicare is not simple or obvious. It involves many critical choices, and difficult questions about how to administer as well as how to design a practical, market-like system for determining prices. An additional complication is that this change occurs after more than 15 years of administrative pricing, and many parts of the system are reluctant to change.

1.1.1 Baltimore, 1996

In 1989, HCFA began a series of research studies to consider how competitive pricing might be adapted to Medicare and began to discuss alternative payment systems with health plans. There was little interest in further refinements to the existing system, but some interest in moving toward a pricing system that allowed plan bids, rather than government calculations, to determine the level of payment. In 1995, HCFA acted on its statutory demonstration authority to begin the design and testing of competitive pricing for Medicare HMOs. Following design efforts through the first half of 1996, HCFA selected the Baltimore, Maryland, metropolitan area as the first site for the demonstration. Baltimore was chosen for several reasons, including its relatively high payment rate, its high commercial but low Medicare market share for HMOs, its relatively large number of Medicare HMOs, and its proximity to HCFA headquarters (which would permit the agency to monitor the demonstration closely).

Whatever the advantages of the Baltimore site, the demonstration faced substantial opposition there. Opponents – area health plans, state officials, and local Congressional leaders – focused on five aspects of the demonstration. First, under the demonstration design, the government would set a cutoff price after inspecting the bids. Health plans that bid over the cutoff price would have to charge a premium based on the difference between their bids and the payment rate. Health plans objected to having to charge a premium. Second, the discretionary cutoff price gave HCFA the latitude to adjust the payment level to limit beneficiary disruption, depending on the actual distribution of bids. But health plans objected that they needed a clearer idea of the payment method in order to prepare bids.

Third, health plans objected to HCFA's proposal to use a third-party contractor to enroll beneficiaries, rather than having beneficiaries enroll directly with the plans. Fourth, state officials expressed concerns about adverse interactions between Medicare competitive pricing and Maryland's unique hospital rate-setting system. Concerns were also expressed that beneficiaries would be confused if the demonstration were introduced at the same time as a new Medicaid managed care initiative scheduled to begin during the same period as the Competitive Pricing Demonstration. Finally, Baltimore plans objected to an HMO-only demonstration that required them to compete on price, but left the Medicare FFS sector untouched. They argued that this approach did not give them a "level playing field," as Baltimore's small Medicare HMO sector would be put under competitive pricing pressures without similar pressures being put on Medicare FFS.

Political opposition by the Maryland Congressional delegation galvanized under the leadership of Senator Barbara Mikulski and Representative Benjamin Cardin. Facing the likelihood of Congressional action to block the demonstration, HCFA abandoned the Baltimore site in the summer of 1996.

1.1.2 Denver, 1997

After the demise of the Baltimore effort, HCFA reviewed its experience there and worked through an analysis of alternative demonstration sites. In February 1997, HCFA selected Denver as the next site. Denver met a series of criteria for site selection, similar to the criteria used to select Baltimore. Denver had an above-average payment rate for M+C plans and enough health plans in the market to ensure competition in bidding. While the managed care enrollment was larger in Denver than Baltimore, it was considered still sufficiently small to avoid unduly multiplying the consequences of any mistakes or disruption. Denver did not have any Medicare or related demonstrations – nor did it have any obvious elements of the state payment or other policies – that might conflict unacceptably with the competitive pricing demonstration. In one respect Denver was superior to Baltimore. Denver constituted a more distinct geographic market area, which would facilitate marketing of the demonstration and segregate demonstration from non-demonstration enrollees in a manageable way. HCFA meanwhile explored the political climate in the state. Indications were that the demonstration might be better received in Denver than it had been in Baltimore.

HCFA approached the Denver site with essentially the same demonstration design as had been proposed for Baltimore.³ The Denver demonstration ultimately met a fate similar to the Baltimore demonstration. Area health plans intensely opposed it from the start, focusing their criticism on virtually the same elements that were criticized in Baltimore: the third-party enrollment broker, the absence of FFS from the demonstration, the requirement for high-priced plans to charge a premium, and the difficulties of bidding without knowing where the government would set the payment rate. In addition, Denver plans expressed

January 19, 2001 Page 5

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³ There was one change of note. Health plans in Baltimore had objected to the prospect of having to charge a premium, if they bid over the cutoff price. Industry representatives suggested that high-bidding plans be given the option to take a dollar-for-dollar cut in government payments, in lieu of having to charge a premium. HCFA included this feature in the proposed Denver demonstration design.

concern about disrupting the market at a critical time and also voiced worries about the dangers of "low ball" bids – bids below the economic costs of service that would enhance bidders' market shares but, plans alleged, endanger quality.

Following meetings with the plans, HCFA issued its bid solicitation package on April 1, 1997. A bidders' conference was held on April 11, and bids were due May 15. The Colorado HMO Association, along with insurers and others, brought suit against the project, claiming among other things that an injunction was essential in view of potential harms to beneficiaries, arising from a design developed by the government without consulting affected parties. The judge hearing the case issued a restraining order temporarily halting the demonstration just minutes before bids were due. However, some plans had submitted their bids in advance of the final deadline, and HCFA was able to inspect those bids. On initial inspection, these bids met HCFA's requirements for the bidding. The judge's decision, however, postponed further consideration of these bids and froze the demonstration in place, pending further judicial proceedings.

While judicial proceedings moved forward, political opposition to the demonstration – slower to organize in Denver than Baltimore – had crystallized. This time, Senator Ben Nighthorse Campbell led the opposition. Senator Campbell succeeded in having language barring the demonstration inserted in a disaster relief bill. President Clinton signed the bill.

The Denver demonstration thus suffered the same fate as the Baltimore experience, albeit with the added involvement of the courts in the Denver case. A full legal test never occurred. But court action delayed the demonstration long enough for political action to take effect. At the time it was stopped, the Denver demonstration was close to a key event: the receipt of all bids. Nevertheless, the Denver initiative at least proved conclusively that HCFA could prepare a request for proposals (RFP) for Medicare HMOs in a very short time, and HMOs could respond to the RFP. The Denver initiative also likely paved the way for the next major development: a Congressionally mandated demonstration.

1.1.3 The BBA-mandated demonstrations: Kansas City and Phoenix, 1999

Shortly after Congress passed legislation to block the Denver demonstration, the Senate passed a competitive pricing amendment to what became the Balanced Budget Act of 1997. The BBA enacted major changes in the administrative prices Medicare paid to managed care organizations (now part of a group of organizations termed "Medicare+Choice" plans). In addition, the legislation gave DHHS a broad Congressional charter to design and implement competitive pricing demonstrations for Medicare: specifically, one demonstration for capitated plans (Sections 4011 – 4012 of the BBA), and five demonstrations for Part B items selected by the Secretary of DHHS, with oxygen and oxygen equipment included in at least one of the Part B demonstrations (Section 4319). These provisions on competitive pricing were among the imposing array of BBA provisions affecting virtually every aspect of managed care services in Medicare.

With respect to the demonstration for M+C plans, BBA gave DHHS authority to demonstrate competitive payment systems for Medicare+Choice organizations. But BBA made no reference to demonstrating a competitive payment system for traditional FFS Medicare. As a result, DHHS lacked statutory authority to include traditional FFS in the demonstration.

The legislation meanwhile required the demonstration to be designed and implemented with extensive stakeholder involvement to adapt competitive pricing to Medicare. CPAC was to develop recommendations for the basic demonstration design and to designate demonstration sites; and AACs at each demonstration site were to assist in implementing the demonstration and in adapting the overall design to local circumstances and concerns. Finally, BBA required the Competitive Pricing Demonstration to be implemented in a budget-neutral way in each year at each site. Budget neutrality is a standard condition for most demonstrations because there is usually little interest in concepts that increase costs. However, the requirement caused a problem in the Competitive Pricing Demonstration. Because of the budget neutrality condition, HCFA could not pay "bounties" to demonstration sites to induce them to join, nor would it be possible to trade costs across areas or across years. Savings in higher cost sites could not be used to offset increased costs generated by market pricing in other demonstration sites.

Demonstration design

CPAC produced its own statement of the demonstration's objectives: to test the competitive pricing model; to protect the interests of beneficiaries; and to establish fair rules for the marketplace. To implement these objectives, CPAC's demonstration design was comprised of four major components⁵

■ Eligibility and participation of plans – Under the CPAC design, all M+C plans are eligible and must participate in the demonstration, with one exception: Medical Savings Accounts. MSAs have benefit structures and other features which are incompatible with other health plan types in a

⁴ The AACs were assigned four decisions by the CPAC: 1) specification of the "market norm" standard benefit package in each site; 2) choice of the median or the enrollment-weighted average bid as the government contribution rule; 3) whether to exercise an option to delay Medicare's new PIP-DCG risk adjustment system in the first year of the demonstration; and 4) deciding whether plans should submit separate bids on each county in the demonstration area, or bid on a base or reference county, with payments to other counties determined by payment ratios under the current system.

⁵ The demonstration design is summarized in the Competitive Pricing Advisory Committee, "Report to the Secretary of the Department of Health And Human Services from the Competitive Pricing Advisory Committee" (March 1999); and in the formal minutes of CPAC meetings after March 1999. CPAC decisions were made after careful examination of alternatives and detailed briefings and assessments from experts in the field. For example, CPAC received expert briefings and research papers on: a) health plan competitive pricing, b) the positive and negative lessons of HCFA's unsuccessful attempt to test competitive pricing at the Denver site, c) HCFA's risk adjustment methods, and d) HCFA's quality and access measurement methodologies. In these areas and others, HCFA's technical assistance contractor (Abt Associates, with its subcontractor, the University of Minnesota, and expert consultants) provided research and option papers to inform the CPAC decision process.

competitive pricing demonstration. CPAC was advised that HCFA did not have the authority to include FFS Medicare in the demonstration, and the committee acceded to that limitation. In general, CPAC decided to use conventional Medicare practices to qualify plans for the demonstration, but with certain adjustments. New plans were to be permitted to participate in the bidding before they were fully qualified, but could not enroll beneficiaries until they were fully qualified. CPAC gave employer-sponsored retiree health programs flexibility in the demonstration, because CPAC did not wish to interfere with employers' ability to negotiate different discounts and alternative benefit packages for their retirees. End-Stage Renal Disease (ESRD) patients were exempted from the demonstration.

- The benefit package In view of the need for the government to assess bids across plans and to provide beneficiaries with comparative information on managed care alternatives, CPAC recommended that all plans submit bids on a common or "standard" benefit package. This recommendation followed the advice of experts from public and private health benefit programs. demonstration's standard benefit package was to be based on a national minimum standard package composed of the statutory benefit with a limited outpatient prescription drug benefit (covering a minimum of \$500 of expenditures with cost sharing). Enhancements beyond the national minimum were permitted to the extent of the market norm in each demonstration site, as recommended by the Area Advisory Committees, in (Thus, prescription drug benefits could be consultation with HCFA. expanded beyond \$500 to the area norm, and other benefits included in the area norm could be added to the statutory benefit.) The point here was to minimize beneficiary disruption by ensuring that the baseline benefit package under the demonstration would be: (1) no different than what plans generally would have offered without the demonstration, and (2) available from at least some plans for zero premium, given how the government contribution to premiums was set (see below). Plans also were permitted to offer add-on supplementary benefits at full cost to beneficiaries, beyond the standard benefit package and without restriction on the number or type of such benefits. This provision was designed to give plans virtually unencumbered flexibility to add benefits to the standard package. Six months after the effective enrollment date associated with an open enrollment period, plans were allowed to enhance, but not reduce, their supplementary or standard benefits. This provision was in the nature of a safety valve, to permit all plans (high as well as low bidders) to formulate mid-stream adjustments between annual bids.
- The bidding process The bidding cycle was one year. Bids were to apply only to the defined demonstration area. HCFA was scheduled to conduct public pre-bid conferences in each demonstration area. Confidential discussions could be held with health plans only if needed to clarify or justify terms of the bids they submitted. Both the Kansas City and Phoenix AACs

decided that in market areas with multiple counties, M+C plans should submit a bid for a base or reference county, with government payments for enrollees from other counties determined by the ratios of conventional M+C payments across those counties.

Government contribution to premiums – CPAC recommended that HCFA set the government contribution to premiums (referred to as the "cutoff price") at either (1) the median bid (adjusted to reflect available capacity in plans bidding low) or (2) the enrollment-weighted average bid. Both the Phoenix and Kansas City AACs requested that HCFA set its contribution at the higher of the median or enrollment-weighted average bid, and CPAC approved this proposal. When M+C plans submit high bids (bids over the cutoff), the excess of their bids over the cutoff is converted into a beneficiary premium. Plans submitting bids below the cutoff are paid the cutoff rate and allowed to: (1) retain the difference, (2) add benefits worth the difference, (3) offer a rebate in cash equal to the difference (up to the amount of the Part B premium), or (4) establish some equivalent combination of these three options. Risk adjustment was to be done by the same method as for nondemonstration sites, although the AACs were allowed to delay the first year of health-based risk adjusters and, if they chose, to propose a new risk adjustment system. The delay option was designed to minimize the amount of change when the demonstration was introduced (i.e., delay made it possible to introduce competitive pricing amidst "old" risk adjustment). The second option was designed to give the AACs freedom to experiment if they chose, particularly in the out years of the demonstration (it would in any event take time to develop and implement any alternative system). All beneficiaries were to pay the same premiums for the same benefits – i.e., there was to be no adjustment in out-of-pocket premiums for risk category or county of residence. Finally, CPAC considered ways to link financial incentives to the quality of care provided by health plans. recommended that HCFA should follow current Medicare practice for the early years of the demonstration. However, the committee expressed its intent to formulate quality initiatives for out-years of the demonstration.

Selection of sites by CPAC

Site selection was one of the most important tasks facing CPAC. The BBA underscored the importance of CPAC's role in site selection, by making the CPAC's site selections binding on DHHS.⁶ Accordingly, the committee devoted extensive attention to this issue.

The site selection process began early in CPAC's deliberations, with consideration of the kinds of information the committee would like to have to appraise potential sites.

⁶ See Sections 4011(b) and 4011(c) of the BBA.

CPAC worked from the demonstration objectives, described earlier, to establish three types of sites to be considered for the demonstration:

Model 1: Sites with high AAPCC rates and <u>low M+C</u> market penetration, that

satisfy certain other market and beneficiary constraints

Model 2: Sites with high AAPCC rates and high M+C market penetration, that

satisfy certain other market and beneficiary constraints

Model 3: Sites with low AAPCC rates and two or more M+C plans, that satisfy

certain other market and beneficiary constraints

Using data on market characteristics, beneficiary and other population characteristics, and health system characteristics, CPAC narrowed the list of potential sites from 319 Metropolitan Statistical Areas to 19 Model 1 sites, 23 Model 2 sites, and 14 Model 3 sites.

Subsequent discussion of Model 3 sites raised critical issues of budget neutrality. As noted earlier, the 1997 BBA legislation explicitly required that the demonstration be budget neutral, in each site in each year of the demonstration. In "low-payment" areas – where M+C plans were charging out-of-pocket premiums for benefit packages scarcely more generous than the basic Medicare entitlement – it would not be possible for HCFA to set the government's contribution to premiums at either the median or enrollment-weighted average for the minimum benefit package specified by CPAC (i.e., including a \$500 outpatient prescription drug benefit) without violating the budget neutrality constraint. This meant that the demonstration could be conducted only in high-payment sites where the demonstration almost certainly would pose a threat to historically high payments. In the end, such sites were hostile to the demonstration, even after HCFA pledged to consider arrangements to keep any savings from the demonstration in the local site.

Narrowing the list of Model 1 and Model 2 sites from 42 to 9 was accomplished using data again collected at CPAC's request by the HCFA Regional Offices. Following a series of procedural votes, the committee voted unanimously in January 1999 to recommend the most highly ranked site for each model: the Kansas City metropolitan area (Model 1) and the Phoenix-Mesa metropolitan area (Model 2).

Implementation of the demonstration in Kansas City and Phoenix

After the two sites were selected and CPAC issued a formal report to the Secretary of DHHS,⁷ the Department selected Area Advisory Committees in each site. Implementation planning began, involving HCFA's Central and Regional Office staffs (and HCFA's technical assistance contractors) to support the AACs in their deliberations.

January 19, 2001 Page 10

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⁷ CPAC, "Report to the Secretary of the Department of Health And Human Services from the Competitive Pricing Advisory Committee" (March 1999).

The Kansas City AAC met for the first time on March 22, 1999, under the direction of Edward N. Holland, Assistant Vice-President for Corporate Benefits at the Sprint Corporation. By the completion of its fourth meeting on May 12, the Kansas City AAC had completed the four tasks assigned to it by the CPAC, although committee concerns in such areas as beneficiary education and outreach, beneficiary disruption, the AAC's role in the bid evaluation process, and other areas promised a busy role and a continuing agenda for the committee.

The Phoenix AAC met for the first time on March 31, 1999, under the direction of Joseph Anderson, President and CEO of Schaller Anderson, Incorporated. The AAC voted to request a one year delay in the demonstration, citing concerns about the effect of the demonstration on beneficiaries, health plans, and providers. On April 20, the AAC finalized its decision on the boundaries of the demonstration area. At their May 18-19th meeting, the AAC voted on the government contribution method, replicating the Kansas City AAC's recommendation that the contribution be set at the higher of the median or weighted-average bid.

On May 13, CPAC met with representatives from both AACs to hear progress reports, and a request from the Phoenix AAC to delay the demonstration. The chairman of the Kansas City AAC reported that the committee in Kansas City had completed the tasks delegated to it, although continuing participation and oversight were required to maintain the community's interests in the demonstration. The chairman and representatives of the Phoenix AAC reported on their progress and presented the case for a delay. CPAC granted an extension of three months to Phoenix. Kansas City was given the option to delay the demonstration for three months, if it so chose.

HCFA proceeded to issue the bid solicitation package to health plans in Kansas City on July 12, 1999. A bidder's conference for Kansas City was scheduled for July 28, and bids were due on August 16. Shortly thereafter, on July 22, both CPAC and the Kansas City AAC met in Kansas City. Kansas City AAC members voted by a small majority to request a one-year delay in the demonstration, to allow more time for beneficiary and provider involvement in the implementation process. At the CPAC meeting that immediately followed, the chairman of the Kansas City AAC reported that the AAC had completed its tasks, but that there had been a vote to delay the demonstration for one year. Representatives from the Phoenix AAC requested a nine-month delay for the demonstration. CPAC voted to delay the demonstration for one year in both sites.

The changing economic and political context of the demonstration, 1997 – 1999

At the time the CPAC acceded to the AAC requests for delay, important changes had occurred in the market for M+C plans, in comparison to the early months of the project. Early in the project – indeed, going back to the days of the Baltimore and Denver demonstration efforts – serious fears were voiced about Medicare's financial vulnerability, especially in the not-too-distant future when the baby-boom generation would retire. The best available research (e.g., Brown et al., 1993) suggested that HMOs had not saved Medicare money, given biased selection in managed care enrollments. Meanwhile, the

pricing of managed care services seemed to be part of the fiscal problem, as plans appeared overpaid in some areas ("free" benefits well beyond the entitlement were being offered in a large number of service areas, and these free benefits were correlated with the Medicare payment rates⁸). System-wide, total health care expenditures were relatively stable by 1997, after experiencing high growth rates earlier in the decade. At this time, enrollment in M+C and its predecessors was growing quickly (more than doubling from 3.1 million in 1995 to 6.3 million by 1999¹⁰), health plans' Medicare business appeared generally profitable, and HMO participation in the Medicare program was growing quickly (increasing from 181 contracting organizations in 1995 to 346 organizations in 1998¹¹). In this robust setting, it was politically tenable to argue, as HCFA had done in the years before CPAC, that the prices Medicare paid for managed care services should be more disciplined. In effect, competitive pricing would bring prices into line with costs across different areas, and would allow the government to share in the savings that managed care could provide.

By 1999, there was a transformation in this conception of the problem and in the related political context. Perhaps the key event was the Balanced Budget Act of 1997. While it gave rise to the Competitive Pricing Demonstration, the BBA also gave rise to a new pricing methodology for Medicare's capitated plans. Where the Competitive Pricing Demonstration proposed to rescale prices area by area in a market-like bidding process responsive to local cost variations, the BBA proposed to squeeze prices formulaically, bringing new resources to low-paid areas and forcing higher paid areas closer to the national average. By 1999, BBA prices were having a systematic effect nationwide in reducing the growth of payments to M+C plans (as well as other Medicare providers, to be sure). This squeeze on M+C prices made it seem that prices were already controlled, albeit that these controlled prices remained administrative prices, with unexplained variations across areas. Other factors were important as well. Continued years of general prosperity (along with BBA price controls) moved the threat of Medicare insolvency further into the future and reduced the sense of more imminent disaster that provided some of the sense of urgency behind the movement to reform Medicare pricing. Meanwhile, health care costs incurred by health plans, having stabilized in earlier years, began to increase more rapidly, driven by pharmaceutical expenses and other factors. Among other things, these cost increases threatened to increase the financial pressure faced by M+C plans offering drug benefits, as well as promising increased supplementary premiums for Medicare beneficiaries in FFS.

As the effects of these various factors played out in markets across the country, the earlier measures of robust growth all showed signs of reversal: enrollment growth in M+C plans softened, plan financial performance appeared less strong, service area reductions increased, and M+C organizations' participation in the Medicare program declined for the first time in over a decade. Where earlier in the 1990s, the growth of Medicare managed care and the desire of plans to participate in that growth seemed inevitable, that was no longer true by the end of the decade; and the BBA threatened to continue rigid reductions in the growth of Medicare payment rates, especially in high-payment areas, even as health plan

⁸ McBride, 1998.

⁹ Indeed, one summary (Levit, et al., 1998) described 1997 as a "placid panorama" of health spending control.

¹⁰ Health Care Financing Administration, "Medicare+Choice: Changes for the Year 2000," undated.

¹¹ Ibid.

expenses (especially drug costs) were increasing. These changes undermined the sense of dynamic growth surrounding reform efforts earlier in the decade. It became more difficult politically to assert the need for the discipline of competitive pricing, notwithstanding that the key justifications for competitive pricing still were true: M+C prices still were the product of administrative methods, and the variations in M+C prices still bore no necessary relation to the underlying costs of service.

Congress stops the Kansas City and Phoenix demonstrations

In this changed economic and political context in 1999, Congress was being pressed by local interests and the health care industry to stop the Kansas City and Phoenix demonstrations. Congress began in the summer of 1999 to consider various legislative vehicles to that end. These amendments had the public backing of the Arizona, Kansas, and Missouri Congressional delegations. In response to these initial legislative efforts (which came in the form of amendments to the Patient Rights Bill passed by the Senate), the cochairs of CPAC, Robert Berenson, Director of the Center for Health Plans and Providers at HCFA, and James Cubbin, Executive Director of Health Care Initiatives for General Motors, wrote to Representative William Thomas, Chairman of the Subcommittee on Health of the House Ways and Means Committee:

The Balanced Budget Act gave CPAC the sole authority to select sites for this demonstration. If Congress decides to override CPAC's decision on sites and take action to exempt Kansas City and Phoenix as demonstration sites, in our judgement, CPAC would not be able to carry out its mission as specified in BBA 97.

When the Patients Rights Bill stalled in the House, the Senate attached amendments to H.R. 3426 (the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999) and the Consolidated Appropriations Act 2000 (which enacted H.R. 3426 into law). As noted earlier, these amendments stopped all appropriations to implement the demonstration in Kansas City and Phoenix and set forth a series of questions on which CPAC would have to report before implementation could resume. In any event, implementation was prohibited until at least January 2002.

1.2 General lessons of the Competitive Pricing Demonstration to date

As noted at the beginning of this chapter, competitive pricing is a fairly simple idea, but the history of competitive pricing for capitated plans suggests a series of difficulties. In the wake of Congressional action to halt the demonstration in late 1999, it will be useful to consider the lessons of this experience so far and to provide the committee's view on how to proceed, before answering the specific questions Congress has asked. Any sense of "lessons" in this experience of course will depend on who is drawing the lessons. The lessons drawn below represent areas of general agreement, across the diverse interests represented on the CPAC.

These lessons can be divided into four areas: designing and implementing competitive pricing; education, communication, and building consensus; providing

information critical to the Medicare reform discussion; and solving the main problem with competitive pricing – political opposition.

1.2.1 Designing and implementing competitive pricing

1. CPAC was able to discharge its Congressional mandate with deliberation and dispatch within the constraints of federal regulations. In the process, CPAC validated the premises of the consultative arrangements that Congress designed.

Perhaps the most important lesson of all is the most basic: CPAC was able to carry out its Congressional mandate with deliberation and dispatch, within the constraints of federal regulations. It was indeed possible to set up a committee of diverse national experts independent of DHHS to bring key stakeholder perspectives to bear on the major decisions concerning demonstration design, site selection, and implementation. It is useful to note the rapid pace of the committee's accomplishments: CPAC held its first meeting in May 1998, and by January 1999 the committee had agreed on a demonstration design, selected sites, and outlined tasks to be addressed by the local AACs. The CPAC accomplished all of this, notwithstanding the political controversies surrounding competitive pricing issues, the sometimes sharp divisions of opinion on the committee, and the complex constraints – procedural and substantive – under which the committee operated. In the process, the CPAC validated the premises of the consultative arrangements that Congress had established in the BBA. Meanwhile, the work of the AACs provided a practical mechanism to adapt national competitive pricing models to variations in local circumstances and preferences, as detailed in items below.

2. The demonstration experience to date has provided practical experience in how to balance competing concerns in the standardization of bids.

The proper degree of "standardization" of the standard benefit package is a complex issue. For example, insufficient standardization might complicate the government's comparison of bids and might make it more difficult for beneficiaries to compare plan packages. Excessive standardization would make comparison of bids easier for the government and comparison of plan packages easier for beneficiaries, but it could inhibit competition and innovation in benefit offerings. This issue is an important one, as some key reform proposals (e.g., the proposals of the Clinton Administration) envision plans bidding on a standard benefit package of some kind. The Competitive Pricing Demonstration already has produced a wealth of information on how to balance the competing concerns that standardization can raise, as well as revealing other complexities of setting a standard benefit package in a competitive bidding environment. In both Kansas City and Phoenix, the local AACs succeeded in formulating standard benefit packages that reflected the differing emphases of the two communities within the constraints that the demonstration presented, such as budget neutrality.

January 19, 2001 Page 14

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¹² See Chapter 5 below for a discussion of the costs and benefits of standardizing the benefit package.

3. This practical experience in setting standard benefit packages includes detailed experience in reconciling the many different dimensions of prescription drug benefits offered by area plans.

The Competitive Pricing Demonstration – notably, the work of the AACs – offered a practical process for reconciling the many important dimensions of plans' drug benefits. The deliberations over drug coverage by both the CPAC and the local AACs in Kansas City and Phoenix already have explored the issues of formularies, copayments for multiple- and single-source drugs, expenditure caps, which prices (e.g., acquisition cost versus average wholesale price) are applied against the benefit, and what prices beneficiaries must pay after the cap is reached (e.g., retail pharmacy prices or plan acquisition prices). In the course of these discussions, substantial beneficiary concerns were addressed. This experience can serve as a model for reconciling the competing concerns associated with prescription drug benefits in future efforts.

4. Competitive pricing is a major administrative undertaking, and the demonstration has offered concrete experience in how to address those challenges.

Competitive pricing – whether in the form of the Competitive Pricing Demonstration, the Breaux-Frist proposal, the proposals of the Clinton Administration, or others – represents a major administrative undertaking. The Competitive Pricing Demonstration provides an opportunity for HCFA to test the administrative systems necessary to run a competitive pricing program for M+C plans. Thus far, the demonstration has provided important information about the details of administering a competitive pricing system, e.g., problems of educating beneficiaries and designing the standard benefit package on which health plans bid.

The various demonstration attempts (as far as they have gone) have shown that HCFA faces some important limitations (especially with reference to the consensus-building activities discussed in Section 1.2.2 below), but was able to move quickly to implement most other features of competitive pricing. In Denver, HCFA prepared and issued a bid solicitation package for an entire metropolitan area in less than two months. Health plans responded to it with very little difficulty, and HCFA was on the verge of receiving all of the bids for evaluation, when the demonstration was halted by a judge and by Congress. HCFA brought the Kansas City demonstration site to within sixteen days of receiving and opening the bids in August 1999, before the AAC voted to delay the demonstration. Meanwhile, the proper administrative approaches to certain novel features in the Competitive Pricing Demonstration and in other reform proposals – e.g., the proposal to allow premium rebates to beneficiaries for low-cost plans – could involve fairly intricate administrative processes (e.g., in working out who actually issues the rebate checks). The ground work for those efforts has begun.

5. When demonstrations require local input for design and implementation decisions, a mechanism for soliciting local input will be needed. The Competitive Pricing Demonstration has shown how this might be done.

The BBA set up AACs to advise on the implementation of competitive pricing in each local site. As noted earlier, the AACs were assigned four decisions by the CPAC: 1) specification of a standard benefit package in each site representative of the local market norm; 2) choice of the median or enrollment-weighted average bid as the government contribution rule; 3) whether to exercise an option to delay Medicare's new health-based risk adjustment system in the first year of the demonstration; and 4) whether plans should submit separate bids on each county in the demonstration area, or bid on a base or reference county, with payments to other counties determined by payment ratios under the current system. The AACs provided a practical mechanism to reflect variations in local circumstances and preferences. In Kansas City and Phoenix, the AACs provided important information about the local issues associated with competitive pricing for health plans: in particular, in such areas as drug coverage, beneficiary preferences and the quality of patient care, the balance between cost sharing and limits on coverage, and other matters. The AACs will remain active throughout the demonstration and will continue to provide those important assessments.

1.2.2 Education, communications, and building consensus

1. HCFA and the CPAC underestimated the importance of communication and education with plans, providers, beneficiaries, and other stakeholders

The Medicare program is important to beneficiaries and has a high profile in both economic and political terms. Any major change to the program must be carefully explained, and every effort should be made to build understanding and support among the affected parties. In each of the four cases to date (Baltimore, Denver, Kansas City, and Phoenix), the efforts to explain and justify the demonstration have been inadequate. For example, a study of the Denver demonstration done for CPAC concluded:

The need to improve how Medicare pays for health coverage was seen by most respondents [local stakeholders interviewed in Denver] as worthwhile, and a valid purpose of the demonstration. The challenge is to communicate this purpose clearly and effectively, and to design the demonstration to minimize... any disruptions, losses in benefits, or increases in premium that may result.... In the Denver experience, the general sense (with some dissents) was that the design came fairly close to striking the right balance, but that the communication component was inadequate. ¹³

More generally, across all of the demonstrations, and most recently in Kansas City and Phoenix, HCFA and the CPAC underestimated the importance of communication and education with plans, providers, beneficiaries, and other stakeholders:

January 19, 2001 Page 16

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¹³ John Klein, "Commentary on the Denver Medicare Competitive Pricing Demonstration," report submitted by Abt Associates Inc. to the Health Care Financing Administration and the Competitive Pricing Advisory Committee pursuant to HCFA Contract #500-92-0014 (September 16, 1998), pp.4-5.

- The communication and education effort should have been more proactive, attempting actively to educate local stakeholders right at the start. Even as the demonstration sites were being selected, HCFA and the CPAC should have been ready to go into the field to explain the decisions and the reasons for them. For example, editorial boards, Congressional delegations, provider associations, beneficiary groups and others should have been briefed immediately. These initial briefings should have been actively followed up, with answers to questions, responses to criticisms, and careful efforts to build consensus. There should have been a common language to explain the demonstration to beneficiaries and their providers and frequent briefings and updates for them. Efforts along all of these lines were in fact pursued, but not soon enough or actively enough.
- HCFA and CPAC should have had an active "crisis management" strategy, so that negative or misleading attacks could have been answered as quickly and as forthrightly as possible.
- The CPAC should have been more involved in the demonstration roll out and implementation. This more active role would have included more outreach to Congress and other local political leaders, as discussed later, as well as to other stakeholders in the demonstration area. For example, CPAC could have answered questions right at the beginning about why Kansas City and Phoenix were chosen in the first place. The selection process followed a series of deliberate steps, but went unexplained as key audiences for the demonstration puzzled over the choice and criticized it.

It thus is clear that a more active education, communication, and consensus-building campaign would have been helpful. However, three important caveats should be noted. First, an active consensus-building effort would have been difficult in any event and especially under the open-meeting requirements of this demonstration. The work of the CPAC and the AACs had to be done in public, as provided by the Federal Advisory Committee Act (FACA). The FACA requirement meant that no one could reach a binding decision or bargain outside immediate public scrutiny, and then quietly build a consensus of support behind it. Instead, all decisions were made in public, with lines of opposition quickly drawn before any helpful consensus-building could take place. Opponents were not subject to the same constraints and were united in their opposition.

Second, the demonstration did not fail simply because of failures of *process* along the lines of the consensus-building suggested above. Note the comments of an independent evaluator, reviewing the CPAC/AAC process:

As of April, 2000, the [Competitive Pricing Demonstration] has not been implemented and has been delayed several years from the original schedule. Having a national blue-ribbon stakeholder/expert panel (the CPAC) independently design the demonstration based upon careful deliberation, and consultation from committees of local stakeholders (the AACs) has not been sufficient to achieve the timely implementation of the [Competitive Pricing Demonstration]. "In the end, [the CPAC and AAC] didn't matter," as one interviewee put it.

The reason the advisory committees "didn't matter" was that the [Competitive Pricing Demonstration], as currently designed, is not perceived as being beneficial to local stakeholders.¹⁴

It is thus a mistake to assume that the real problem here is one of consensus building, rather than a problem reflecting disputes over the substance of what was being attempted (and, under the constraints of the demonstration, what could be attempted).

Finally, there are limits to what HCFA realistically can do in the area of education, communication, and consensus-building, and it is worth thinking about what the proper role for HCFA should be:

- HCFA is charged to support the integrity of the Medicare program. HCFA does not conduct active public relations campaigns, although it does develop and distribute extensive beneficiary education materials.
- HCFA is barred by law from lobbying, particularly to Members of Congress. In any event, HCFA should not become (nor should it be viewed as) simply another lobbyist.
- The HCFA procurement process is relatively complicated and may not allow sufficient flexibility to do rapid-changing public relations campaigns. For example, CPAC expected HCFA to mobilize an outreach campaign to seniors early in the implementation, to reassure beneficiaries and address their questions. But the process proved cumbersome for issuing explanatory letters, holding meetings, and providing other aspects of a comprehensive campaign.

As a result, it will be difficult for HCFA to undertake an aggressive and flexible consensus-building campaign to help overcome the difficulties of implementing any particular competitive pricing approach. There are limits to what HCFA can do to address the intense political controversies of competitive pricing.

2. The demonstration needed more active support to build and maintain consensus as implementation approached. This political role could only be performed by Congress.

It appears obvious that more needed to be done, and sooner, to ensure political support in Congress and the public for the direction the demonstration would take. This became especially important as: (a) the effects of the BBA on M+C payments, the resurgence in health plan expenses, the declines in M+C enrollment growth, and other factors began to affect M+C organizations and the M+C program generally, reversing the

January 19, 2001 Page 18

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¹⁴ Health Economics Research, "Evaluation of the Competitive Pricing Demonstration Advisory Committee Process: Final Interim Report," report submitted pursuant to HCFA Contract No. 500-95-0048, Task Order 7 (June 19, 2000), p. ES-6.

earlier, more favorable indications; and (b) large issues of Medicare reform began to overtake the demonstration.

But who could be responsible for building the needed political support? HCFA could not lobby Congress or local leaders, for reasons described above. Unfortunately, CPAC could not do it either, at least given how the committee was constituted by Congress. CPAC's charter from the BBA was to design the demonstration, select sites, and make recommendations on monitoring and evaluating the demonstration. composed of a variety of different stakeholders and was clearly intended by Congress to be a deliberative committee. It had no authority to designate a leader to take charge of any consensus-building effort. It had no charter to undertake the kind of bargaining essential to build consensus or to respond actively to the unfolding political struggles over this issue. Indeed, under the requirements of the Federal Advisory Committee Act, CPAC deliberations had to take place in public and with long advance notice. These requirements had many important positive effects: they contributed to the legitimacy of CPAC's deliberations over contentious demonstration issues and endowed CPAC decisions with an authority that would have been impossible for a more opportunistic or unencumbered committee. But they put substantial restrictions on any political entrepreneurship or consensus-building by the committee. Meanwhile, there were no clear places to look for Congressional support – there were no leaders in Congress maintaining active contact with the work of the CPAC. The committee accordingly had to take political support for granted.

Thus, while it is tempting to look to the CPAC for more active advocacy on this issue, and while CPAC might have done more in modest ways to defend its decisions publicly (e.g., to defend its site selection process when site selection was under attack in Phoenix and Kansas City), there were intrinsic limits to the ability of the CPAC to take over political management of the issue. Certainly, the committee was in no position to mount an effort that the importance of this issue and the intensity of the controversy demanded.

There is no simple answer here. But the committee has concluded that the most promising setting for consensus-building on this issue is where the consensus broke down: in Congress. Medicare is a program with enormous responsibilities, and commensurate political controversies surrounding efforts to reform it. A demonstration to reorient the Medicare program to incorporate market-like pricing is not just another Medicare demonstration. The interests at stake are fundamental and require continuing Congressional engagement to withstand the inevitable controversies of any steps to reform. It is Congress' responsibility to maintain political backing for these ventures. CPAC stands ready to cooperate with that activity and to support it, but cannot take the lead in putting the consensus together.

1.2.3 Providing information critical to the Medicare reform discussion

1. Does competitive pricing deliver in fact what it promises in principle?

As noted earlier, the current administrative pricing system for paying M+C plans has been the subject of persistent criticism. The BBA reforms have not changed the underlying problem: information about the true cost of care flows in the wrong direction under the current system, from the organization that knows little or nothing about the true cost of care (HCFA) to the organizations that know as much as possible about the true cost of care (the health plans). The demonstration was developed because competitive pricing has the potential to address the problems that have plagued the M+C payment system since its inception. Whether it is successful in doing so is the primary lesson to be learned from the demonstration.

Competitive prices in some form are central to almost all current reform proposals for Medicare managed care. For example, both the Medicare reform proposal of the Clinton Administration and the National Bipartisan Commission's majority report both recommend scrapping the current system and replacing it with forms of competitive pricing. Although the current demonstration design differs in form and scope from these proposals, the demonstration can provide information on whether the basic promise of competitive bidding – to rationalize prices – is borne out by practical experience in a Medicare+Choice context. That is critical information, especially since, apart from the Competitive Pricing Demonstration, no other direct evidence on the success of competitive pricing for M+C plans is scheduled to be available to inform the Medicare reform debate.

- 1.2.4 Solving what was, within the constraints of the demonstration, the main problem with competitive pricing: political opposition
- The requirement that the demonstration be budget neutral has meant, in practice, that the demonstration could only be run in high payment sites. High payment sites naturally resist the possible loss of resources for their local Medicare beneficiaries and providers.

Medicare was designed as a nationwide entitlement. But managed care in Medicare has become a patchwork of payment rates, the product of an administrative pricing methodology that created high-payment and low-payment areas with little justification. Some areas have free drug benefits of substantial value (e.g., \$2,000 in some cities). Elsewhere, beneficiaries must pay premiums to M+C plans just to obtain what is in essence the entitlement, without supplements. Under the budget neutrality requirement, the demonstration could be introduced only in sites that had relatively high payments. Understandably, these sites did not welcome efforts that might reduce their funding.

In concept, the purpose of competitive pricing is to rationalize prices, not simply to reduce them – which means increases in some areas, reductions in others. For low-payment

sites, the Competitive Pricing Demonstration (with the minimum drug benefit the CPAC required) would promise new money and benefits. If the demonstration were begun at low-payment sites, Congressional and local opposition witnessed in Baltimore, Denver, Kansas City, and Phoenix might be mitigated. But the budget neutrality constraint made consideration of such sites out of the question in the BBA-mandated efforts.

2. Additional thought should be given to beneficiary perception of disruption and how to deal with it under competitive pricing.

Under the demonstration model proposed, high-bidding plans were likely to have to charge a premium. Likewise, low-bidding plans were likely to be able to offer additional benefits or a premium rebate. This prospect of a premium raised a concern in all sites that beneficiaries might be disrupted: specifically, that they might have to change plans (because they could not afford the premium) and might, in the process, have to change their physicians and other providers. Note that this result followed from health plans' insistence that the formula for setting the cutoff price be specified in advance. The "Denver" model (which gave HCFA the discretion to set the cutoff price at a level of its choosing, after inspecting the bids) would have allowed HCFA the latitude to moderate any such results.

Disruption is in fact a misleading term for what is really deliberation or comparative shopping. The model design would, in fact, provide market advantages to plans, as well as disadvantages, depending on plans' submitted prices. Beneficiaries would have a choice to make that would require comparison and consideration of many different factors. However, the term "disruption" rather than "change" became the popular term to use by opponents. A well thought out beneficiary education effort might have prevented a perception of disruption by beneficiaries and their advocates.

The extent of any such disruption or change under the model CPAC approved depended on the bidding behavior of plans. For example, if plans bids were reasonably tightly clustered, no plan would have to charge a premium. There would be little beneficiary disruption in that case. (Widely dispersed bids would have the opposite result, especially if plans with large enrollments submitted much higher bids than their small counterparts.) Meanwhile, in the 1999 – 2000 period, many different varieties of beneficiary disruption are common outside the demonstration in other areas of the Medicare program. For example, in the fee-for-service program, there have been substantial increases in outpatient prescription costs not covered by Medicare and premium increases from the MediGap plans that most fee-for-service beneficiaries use. There have been certain reductions in benefits, service-area reductions, and withdrawals in service areas in the Medicare+Choice program. And so on. These more general disruptions suggest that it is inaccurate to assume that premiums and benefits are fixed and unchanging in the absence of the demonstration.

In its original design, there were a series of ways that CPAC sought to minimize potential beneficiary disruption or change:

• The standard benefit was set to approximate the market norm of the baseline plan, not the entitlement. Setting the standard benefit at this level meant that

all plans bidding at or below the cutoff price would be offering essentially the same benefit likely to have been available in the market – for the same zero premium price – as available in the absence of the demonstration.

- The cutoff price was set above the lowest qualified bid. Setting the price at the lowest bid would have provided reassurance that Medicare was paying no more than what a qualified plan was willing to accept to cover the services spelled out in the standard benefit package. But while it would have allowed Medicare to minimize its costs, it would subject more beneficiaries to the risk of paying a premium. Setting the cutoff price at a higher level (the median or enrollment-weighted average) was a way to balance the need to minimize beneficiary disruption against the need to create incentives for plans to bid low.
- <u>Low-bidding plans were allowed to increase their benefits beyond the standard package</u>. While all plans would bid to the standard benefit package representing the market norm, low-bidding plans could enhance that benefit, and beneficiaries would receive those enhanced benefits for free.
- <u>Plans were to be allowed to waive small premiums</u>. In Kansas City and Phoenix, plans were to be allowed to waive small premiums of less than \$10/month i.e., premiums deemed "nuisances" because they would cost as much to collect as they would generate in revenue, even as they would be irritating to beneficiaries.
- Plans were allowed to enhance their benefits half-way through the bidding cycle. Six-months into the bidding cycle, plans were allowed to enhance their benefit packages for any reason they chose. This provision provided a safety valve to plans and more diverse benefit options for beneficiaries, without undermining the bidding process.
- Special monitoring and analysis capabilities were in place to establish the extent and distribution of any disruption. For the demonstration, HCFA had special technical support and evaluation contractors in place to analyze the character and distribution of any disruption the demonstration introduced.

Later, in the fall of 1999, CPAC added another feature to the demonstration design – giving low-bidding plans the option to offer premium rebates – to help offset beneficiaries' concerns about the disruptive effects of the demonstration. By this time, the demonstrations in Kansas City and Phoenix had run into substantial local opposition, and CPAC and the AACs were exploring ways to make the demonstration design more attractive to beneficiaries. The Clinton Administration had made public a proposal for Medicare reform that, among other things, included a provision for premium rebates. Congress made clear that premium rebates were consistent with demonstration authority (a position soon made explicit in Section 533 of the BBA Refinement Act of 1999). At that point, CPAC decided to revisit the rebate issue. CPAC had set aside the premium rebate option in early design

discussions, following briefings by HCFA on the substantial administrative difficulties of including premium rebates and possible legal difficulties as well (e.g., with the anti-kickback statutes). Now, however, premium rebates were viewed as a useful and authorized tool to make the demonstration more relevant to the Medicare reform debate and more attractive to beneficiaries.

Notwithstanding the attention paid to reducing or offsetting beneficiary disruption in the demonstration design, the failure of the demonstration to overcome political opposition suggests that additional attention should be paid to this area. Analyses of beneficiary disruption should be developed further, and changes in the bidding model should be considered, looking to other Medicare reform proposals and other large public programs for guidance. HCFA should explain what it will do to minimize disruption as much as possible. And methods should be considered to hold areas or beneficiaries harmless from the financial effects of the demonstration, in return for their participation in this important, but unsettling, Medicare experiment. (CPAC sets forth some options for compensating areas and beneficiaries at the end of Chapter 2, below.)

3. Congress needs to give CPAC more flexible tools to fashion a demonstration design that will increase Congressional support and reduce local opposition.

The Medicare Competitive Pricing Demonstration now has an explicit statutory basis, but to date it has not had the support of local political leaders and Congressional delegations critical to its success. For the demonstration to go forward, Congress needs to give CPAC more flexible tools to fashion a demonstration design that will increase Congressional support and reduce local opposition.

Under current legislative authority, CPAC attempted to find ways to make the demonstration more attractive without undermining the key incentives necessary to make competitive pricing work – notably, the incentive for plans to bid low. A number of areas were explored, generally with limited success:

- Reduced regulation One area that was explored on a continual basis was various means to lighten the regulatory burden on plans. This area did not yield major incentives, although a few proposals would have been helpful (e.g., making service-area expansions within the demonstration area follow the bidding process, rather than the more complex process Medicare normally requires).
- Quality incentive pools As noted earlier, HCFA pledged to consider arrangements to invest any local savings from the demonstration in the local site. One such arrangement that was specifically discussed by the CPAC and by the AACs in Kansas City and Phoenix was to set up quality incentive pools, whereby plans with superior performance on agreed quality indices would share in an incentive pool drawn from amounts Medicare would otherwise save in its payment amounts.

- Encourage plan entry in areas with little plan activity If competitive pricing could be introduced in an area with little plan activity, it obviously would be less disruptive, other things being equal. In fact, the strategy of introducing competitive pricing in a low-activity area was one of the motivations for picking the Baltimore site in 1996 (Baltimore had a number of plans but few beneficiaries enrolled in them). The strategy in that form did not work to minimize opposition, but that begs the question of whether competitive pricing could be introduced in an area with no M+C plan activity. In counties without any M+C plan activity, if plans were willing to serve at the current payment rates, they presumably already would be there. Thus, increased payment rates are likely required as a necessary, if not sufficient, condition to induce entry. In CPAC's view, this approach brings us back to the issue of budget neutrality, discussed below.
- Grandfather current beneficiaries In principle, one way to minimize beneficiary disruption and reduce political opposition would be to grandfather current managed care enrollees – i.e., to continue their managed care coverage under conventional arrangements - and to require only new enrollees to come under the terms of competitive pricing. This option would reduce disruption for current enrollees in some ways, although these enrollees still would face the ordinary disruption of the managed care market (e.g., benefit reductions year-to-year as the BBA squeezes price levels in highpayment areas). Meanwhile, the benefits of this approach would come at a very high price. Two different classes of beneficiaries would be created within the same area, with attendant confusion of beneficiaries and increased political conflict over why some beneficiaries fail to qualify for the more advantageous program. Plans would have to run two different marketing programs, two different benefit packages, two different cost sharing arrangements with providers, and so on in the same geographical area, even as demonstration costs would be spread over a much smaller group. With such a small group, problems of risk selection would increase. Due to all of these problems, the competitive pricing process itself would be fundamentally affected. The costs and incentives surrounding a bid would change; and the prices bid could not be interpreted as the costs of serving managed care enrollees generally, but only of the small and unusual population involved in this kind of demonstration.

All of these areas were explored, but it is clear that none of these tools was likely to change the opposition to the demonstration in any fundamental way.

If the Competitive Pricing Demonstration is to go forward, it seems obvious that new approaches will be needed. To fashion these approaches, CPAC needs more flexible tools from Congress. One example of the kind of flexibility that is needed is provided by the recent example of premium rebates. The premium rebate option was not clearly feasible, until Congress gave it explicit statutory authority. As a result of Congress' action, a

premium rebate option was added to the demonstration design, albeit (as it turned out) too late to affect the Congressional move to stop the Kansas City and Phoenix demonstrations.

More of this kind of flexibility will be needed. The most important area where new flexibility is needed concerns funding. The requirement that the demonstration must be strictly budget neutral has substantially impeded the search for a design that could garner more support. A demonstration that brought increased financial resources in some form might mitigate plan opposition and encourage support from beneficiaries and political leaders (see discussion at the end of Chapter 2 below). In turn, important research findings on the effects of a competitive pricing strategy would be available. Note that CPAC to date has not considered strategies that do not promise budget neutral results, since the BBA is explicit in requiring budget neutrality. But it is hard to imagine a way to overcome existing political opposition without more money. If stronger financial inducements could be offered, the way would be open to a much more creative resolution of the political logjam that has stopped competitive pricing efforts to date. For example, if it were possible to bring new funds to demonstration areas:

- 1. CPAC could consider "low payment sites" sites whose BBA payments are so low that the statutory entitlement is available from M+C plans only by paying a premium in addition to the Part B premium. If CPAC chose to introduce the current demonstration model in a low-payment site without any changes, there now would be some plans (the low bidders) able to offer the entitlement plus \$500 prescription drug benefits for no additional premium beyond the Part B premium. ¹⁵
- 2. The demonstration could come to a site and promise to maintain benefit levels for the five years of the demonstration, while other high-payment areas suffer progressive reductions in their benefits as the BBA continues to squeeze payment growth. This kind of promise could only follow the introduction of additional money beyond the budget-neutral amount i.e., budget neutrality would have to be suspended. Such a promise would create a group of winners from competitive pricing that might change the uniform political opposition that has obstructed competitive pricing to date.
- 3. Congress could authorize "hold-harmless" payments to beneficiaries in demonstration areas. The Health Insurance Experiment conducted in the 1970s provides an interesting precedent. The purpose of that experiment was to determine the effect of coinsurance and deductibles on health care spending. Consumers were assigned randomly to different health insurance policies. One of the policies had a large deductible. To avoid having subjects assigned to that policy drop out of the experiment, those subjects were given a lump sum payment equal to the most that they could be required to spend under the policy. Because the lump sum payment was not tied to

January 19, 2001 Page 25

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¹⁵ Indeed, bidders below the cutoff price could reduce the net cost of the Part B premium, by rebating the difference between their bids and the cutoff price (up to the value of the Part B premium).

health care consumption, it did not affect the subject's consumption decisions on the margin. By analogy, beneficiaries in the demonstration sites could be given a lump sum "hold harmless" payment equal to the largest out-of-pocket premium that they would have to pay under the competitive pricing model. In order to avoid biasing the results of the demonstration, however, the payment must be given to all beneficiaries in the demonstration area, not just those choosing a particular plan. Obviously, that could make the hold harmless payments quite expensive.

CPAC has shown it can provide creative solutions when given the latitude, within Congressional guidance. The committee needs more flexible tools now, if it is to fashion an alternative to reduce local opposition and to secure enduring Congressional support.

1.3 Conclusion

The general lessons outlined above have three common themes. First, the Competitive Pricing Demonstration – as far as it has gone – has shown competitive pricing to be a practical approach for Medicare to consider. For example, the decisions involved (e.g., to standardize benefits) appear amenable to reasonable solutions even amidst political conflict. The administrative challenges of running a bidding process with extensive stakeholder input have proved to be tractable.

Second, however, some apparent requirements of competitive pricing have not been readily resolved to date – specifically, the need for effective education, communication, and consensus-building to address at times intense political conflict. In particular, HCFA faces certain legal and other limits in this area, and the CPAC is not constituted or chartered for that role. The more active engagement of Congress would be desirable.

Finally, a related point, the demonstration efforts in Baltimore, Denver, Kansas City, and Phoenix have made it clear that the key impediments to competitive pricing are not conceptual or practical, but rather political. The political opposition is grounded in perceived economic self-interest. The successful implementation of competitive pricing will require the successful resolution of those political problems. Competitive pricing for M+C plans will always have opponents, but it needs more support than it has had to date, if it is to go forward. To secure that support, it will be essential to fashion more creative approaches to demonstration design, approaches that promise a vigorous competitive process but also provide the means to enhance demonstration support. One way to do that will be to give CPAC more flexible tools to revise the demonstration design, site selection, and implementation.

These general lessons provide a useful background for considering the more specific questions Congress has asked the committee. Each of the next four chapters is devoted to one of the issue areas raised by Congress, beginning in the next chapter with Congressional questions concerning the inclusion of fee-for-service in the demonstration.

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Chapter 2.

Including Fee-for-Service Medicare in the Competitive Pricing Demonstration

2.0 Introduction

From the earliest discussions of competitive pricing for Medicare, one of the most important and controversial questions has been whether to include traditional fee-for-service (FFS) Medicare as a "bidding health plan" in the demonstration, along with Medicare+Choice (M+C) plans. Virtually all competitive pricing proposals assume that traditional FFS Medicare still will be available in all market areas, but will have to participate in the bidding process in some fashion (Breaux, et al., 1999; Butler and Moffit, 1995; Dowd, Feldman and Christianson, 1996; and Enthoven, 1988a and 1988b).

CPAC's design for the demonstration excluded FFS Medicare (see Chapter 1). CPAC had some concern about excluding FFS. As expressed in its Design Report,

The CPAC was advised that the intent of the demonstration was to develop a pricing methodology for Medicare+Choice organizations only. But the committee urged HCFA to explore the receptivity of Congress to include fee-for-service in the demonstration. The committee also expressed the judgment that the exclusion of fee-for-service might jeopardize the acceptance of the demonstration by Medicare+Choice plans and limit HCFA's ability a) to measure the impact of competitive pricing and b) to generalize demonstration results to the entire Medicare program. ¹⁶

Notwithstanding this concern, CPAC felt it had no alternative but to exclude FFS from the demonstration. As noted in Chapter 1, the Balanced Budget Act of 1997 gave DHHS authority to demonstrate competitive payment systems for Medicare+Choice organizations. But BBA made no reference to demonstrating a competitive payment system for traditional FFS Medicare.

In any event, most members of CPAC believed that an explicit statutory mandate was required for FFS to be included in the demonstration. Medicare's contracts with private M+C health plans can be made or dissolved on an annual basis and carry no guarantee of availability to beneficiaries. The terms under which FFS Medicare is offered to beneficiaries, by contrast, were specified in the original Medicare legislation in 1965. FFS Medicare is synonymous with the Medicare entitlement, and altering the structure of FFS Medicare, or the government's contribution to the FFS Medicare premium, would raise issues that go to the heart of what Medicare means as an entitlement to beneficiaries. CPAC believed that the inclusion of FFS was such a critical shift in the character of the Medicare benefit that it required explicit Congressional sanction and could not be brought into the

¹⁶ Competitive Pricing Advisory Committee, "Design Report of the Competitive Pricing Advisory Committee," January 6, 1999.

demonstration indirectly – i.e., through the BBA's requirement to test competitive pricing for "Medicare+Choice organizations" or through other legal authority.

As a result, CPAC excluded FFS from its demonstration design, but urged HCFA to explore the receptivity of Congress to include fee-for-service in the demonstration. The committee knew that Congressional action would take time, so that the initial demonstration sites could not include FFS at the outset of the demonstration. However, there were important benefits to having the demonstration begin on an M+C-only basis and including FFS, if at all, only in later years of the project. Specifically:

- If FFS were included, the demonstration could affect a much larger proportion of beneficiaries at any given site than would a M+C-only demonstration, depending on the outcome of the bidding process. Considerable thought needs to be given to how FFS should be included, and additional time would be helpful to work that out. As that was being done, a M+C-only demonstration would provide an opportunity to work out the considerable administrative challenges of competitive pricing for Medicare. It makes sense for the Medicare program to "walk before it runs" i.e., to perfect the adaptation of a bidding process to M+C plans before taking on the much larger task of adapting the entire Medicare benefit to competitive bidding.
- The exclusion of FFS from the demonstration reduced, but did not eliminate, the incentive for plans to bid low. In a demonstration excluding FFS, M+C plans still would have to be concerned about their bids relative to the bids of other M+C plans.
- Meanwhile, to the extent plans bid below the government contribution, they could offer premium rebates to beneficiaries (up to the amount of the Part B premium) and commensurately reduce the price of M+C relative to FFS. ¹⁷ FFS was not entirely insulated from competition as a result.

Thus, there was much to learn from a demonstration that excluded FFS, even as there were important legal and political reasons not to include FFS without Congressional authorization. However, the exclusion of FFS was one of the main reasons health plans gave for their opposition to the demonstration. The American Association of Health Plans (AAHP), in particular, claimed that the demonstration was guilty of "tilting competition unfairly against private plans" if FFS were excluded. The same perspective has been echoed by some members of the Area Advisory Committees (AACs) in Kansas City and Phoenix, as well as some members of Congress. It thus appears that exclusion of FFS from the Competitive Pricing Demonstration – and the ambiguities about any future inclusion of FFS – increased industry and Congressional opposition to the project.

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¹⁷ Premium rebates were a late addition to the demonstration design. See Chapter 1.

¹⁸ Karen Ignani, President of AAHP, quoted in Weinstein, 1999.

In the Balanced Budget Refinement Act passed in late 1999, Congress directed CPAC to write a report reconsidering this aspect of the demonstration design. Specifically, in Section 533 of that act, Congress required CPAC to submit a report on the following:

<u>Incorporation of the original Medicare fee-for-service program into the project:</u> What changes would be required in the project to feasibly incorporate the original Medicare fee-for-service program into the project in the areas in which the project is operational.

This chapter lays out CPAC's thinking on the challenge of incorporating the original FFS program in the Competitive Pricing Demonstration. The chapter also will offer some suggestions and recommendations for how FFS Medicare might be treated in a redesigned demonstration.

2.1 What does it mean to incorporate fee-for-service in the demonstration?

What does it mean to "incorporate" FFS Medicare in the Competitive Pricing Demonstration? The committee assumes that inclusion of FFS Medicare has two main components:

- 1. FFS Medicare must prepare a "bid" that can be compared to the bids submitted by M+C plans. (For the moment, we leave aside questions of just how that would be done.)
- 2. When the government's contribution to premiums is determined, it must be possible for the beneficiary's out-of-pocket premium for FFS Medicare to be different than the current Part B premium, as a direct result of the FFS bid.

Within this broad framework, there are numerous possibilities, which are discussed below (e.g., allowing a rebate of part or all of the Part B premium for low-bidding plans, as described below in Section 2.2). The fact that there are numerous possibilities points to a critical issue in thinking about the incorporation of FFS: "incorporation" is not an all or nothing decision along a single design dimension. There are many different methods and degrees of including FFS, so in principle demonstration designers have some flexibility in how they incorporate FFS. At one limit, FFS would be treated like any other health plan – there would be a FFS bid, along with the bids of M+C plans. This relatively complete form of inclusion would require explicit Congressional authorization, for reasons discussed earlier. Short of that kind of treatment, there are many other ways to link demonstration bids to FFS payments.

2.2 Linking traditional FFS and M+C rates in the CPAC demonstration design: reimbursement caps and premium rebates

In the CPAC demonstration, there was no FFS bid. However, two features of the demonstration linked plan payments to FFS. First, historical FFS costs serve as the basis for determining the M+C payment rates that, in turn, establish the budget neutral cap on the

government contribution to premiums in the demonstration. As implemented by the AACs, this budget-neutral cap became the target level for setting the standard benefit package (that is, the AACs sought to specify a standard benefit package sufficiently generous that M+C plans would be expected to bid in the neighborhood of the cap). Thus, FFS costs would have some effect in constraining the bids by plans, although FFS costs would not directly affect premiums paid by FFS beneficiaries or health plan enrollees.

Second, low-bidding plans were allowed to offer premium rebates. (This option was added to the demonstration design late in the design phase of the project.) These rebates represented a very important link between FFS and the demonstration. If a low-bidding plan was an M+C plan, and that plan offered a premium rebate, it would have the effect of reducing the price of that M+C plan below the Part B premium that FFS enrollees still would pay for their coverage, thereby creating direct price competition between M+C plans and FFS. To be sure, this price competition came in the form of opportunities for reduced premiums for low-bidding M+C plans (a "carrot"), rather than increased premiums for FFS (a "stick"), as would follow from complete inclusion of FFS at most sites. But given the absence of Congressional authorization, complete inclusion of FFS in the demonstration was out of the question. CPAC saw premium rebates as a reasonable compromise: a way to encourage FFS-M+C price competition, without risking radical modification of the FFS entitlement in a way that would require Congressional action. This was not the only way to include FFS in the demonstration, but it was a productive way to balance competing interests, in view of the constraints CPAC faced.

Premium rebates are a key element of certain Medicare reform proposals (e.g., the proposal of the Clinton Administration). A demonstration including premium rebates would provide an important test of how beneficiaries might respond to such rebates. For example, consider what a demonstration incorporating premium rebates might show. If beneficiaries at test sites were sensitive to the price differentials created by premium rebates – that is, if FFS beneficiaries moved in substantial numbers to M+C plans offering rebates of a particular size, and if high-bidding M+C plans lost enrollees to plans offering such rebates – then premium rebates would become a far more interesting policy tool for introducing price competition to the Medicare benefit. Or the results of the demonstration might point in the opposite direction: beneficiaries might be less sensitive to marginal price differences (in the form of premium rebates) than these proposals imagine. Whatever the truth of the matter, the important point is that a demonstration is needed to test beneficiary response to premium rebates – one form of "including FFS" – and that test could occur with the current CPAC design.

2.3 How to incorporate FFS more completely

The CPAC design for the demonstration thus envisioned a particular, partial form of incorporating FFS in the demonstration. What if Congress authorized more complete incorporation of FFS? How should that be done? This section of our report provides a review of the most important issues to consider.

2.3.1 The political challenge

As noted in the introduction, CPAC did not pursue ways of including FFS in the demonstration, given the absence of a clear statutory mandate to do so. But if such a mandate existed, there are a series of political difficulties that must be considered. From the outset, the Competitive Pricing Demonstration has faced intense political opposition from the HMO industry and members of Congress whose constituents were affected by the demonstration. The more complete inclusion of FFS in the demonstration might reduce industry opposition. However, it might not change the opposition of M+C enrollees, such as it is; and it likely would create a new group of opponents: FFS beneficiaries facing the risk of higher premiums.

The high payments to M+C plans in some market areas are a direct result of high FFS costs in those market areas. The ability of M+C plans to offer generous supplementary benefits, including outpatient prescription drug coverage, for the average cost of caring for beneficiaries in FFS Medicare (without those supplementary benefits) could be the result either of favorable selection of M+C enrollees relative to FFS beneficiaries, increased efficiency in M+C plans, or both. To the extent that the M+C plans' excess revenue is due to increased efficiency, the "bid" submitted by FFS Medicare for a uniform standard benefit package will be higher than that of M+C plans, even if a comprehensive and effective riskadjustment system is fully implemented. The current PIP-DCG system is neither comprehensive (it is triggered only by inpatient events), nor fully-implemented (only a portion of M+C plans' payment is subjected to the PIP-DCG adjustment). Thus, assuming that M+C plans enjoy favorable selection relative to FFS Medicare (Call, 1999) and absent a comprehensive risk-adjustment system, the process will be more likely to produce out-ofpocket premiums for FFS beneficiaries than a comprehensive, fully-implemented riskadjustment system.

Congress stopped HMO-only demonstrations in Baltimore, Denver, Phoenix, and Kansas City that affected only a small proportion of the beneficiaries in those cities and that left beneficiaries in the much-larger FFS sector totally unaffected. Would a demonstration that increased the cost of FFS Medicare for most beneficiaries in a demonstration site fare better in Congress than an HMO-only demonstration has done?

It is important to note that the political difficulties of including FFS Medicare in a demonstration of competitive pricing would not necessarily be the same in a larger, national Medicare reform effort. In a national reform effort, at least, no area would be "singled out," one of the key complaints of each of the demonstration areas to date. In a national reform effort, the rules determining the beneficiary's out-of-pocket premium for FFS Medicare would be uniform nationwide (albeit that the actual amount of the premium still would vary from one market area to another). In this way and others, national reform might address difficulties that result from doing the demonstration in just a few local sites.

Another way to take on these political difficulties of more complete inclusion of FFS would be to hold demonstration areas or beneficiaries harmless from the financial effects of the demonstration – that is, to devise compensation arrangements that did not interfere with

the incentives of the competitive bidding process, but still minimized harm to beneficiaries. These options are considered in detail in the final section of this chapter (see Section 2.4).

2.3.2 How would FFS Medicare participate in a Competitive Pricing Demonstration?

In order to include FFS Medicare in a Competitive Pricing Demonstration, some arrangement must be made for FFS Medicare to act like a competing bidder. In this respect (as in many others), the inclusion of FFS represents a major challenge in its own right.

There are two basic approaches for FFS participation. The first is for HCFA to continue to provide the FFS health benefits. The second is to contract with the private sector for provision of FFS Medicare. The primary advantage of the first method is that the HCFA-based option already is in place, and HCFA has many years of experience estimating the average cost of beneficiaries in FFS Medicare.

If HCFA were to submit a competing bid based on something other than the existing FFS structure, there are significant constraints. Exclusion of providers and prudent purchasing practices are limited under HCFA's current legislative authority. In addition, HCFA has faced considerable opposition in its efforts to contract efficiently with health care providers even when legislation permits it (witness the difficulties HCFA has had implementing competitive bidding for durable medical equipment and clinical laboratory services and imposing "inherently reasonable" payments).

If the standard benefit package includes benefits beyond the Medicare entitlement, such as outpatient prescription drugs, responsibility for coverage and payment for these services is an added complexity. It would not be impossible for HCFA to arrange for coverage of outpatient prescription drugs under FFS Medicare for the period of the demonstration, but it adds an additional layer of complexity to the demonstration.

2.3.3 On what benefit package would FFS Medicare bid?

A third issue to consider is that, for FFS to be incorporated in the demonstration, a benefit package must be specified on which to base the FFS bid. The appropriate benefit package for FFS bidding is not obvious. This difficulty follows from the demonstration design. That design provides that all M+C plans bid on a standard benefit package which, in the high-payment demonstration sites, is more generous than the Medicare entitlement. But FFS Medicare is based strictly on the entitlement, not the enhanced package likely for demonstration sites. The issue thus arises as to whether the benefit package for a demonstration that includes FFS should:

- <u>"Level down"</u> All plans, including M+C plans, bid on the entitlement.
- <u>"Level up"</u> All plans, including FFS, bid on the enhanced package.

Allow for different packages – FFS and M+C plans bid on different packages. Suitable analytic adjustments are made to the FFS bid to make FFS and M+C bids comparable.

For reasons set forth below, the third option is the most practical for this demonstration effort.

Level down

CPAC rejected the idea of leveling down when it designed this demonstration. Leveling the M+C benefit package down to the entitlement would create significant disruption among M+C enrollees in the high-payment demonstration sites. Allowing plans to bid on an enhanced benefit that represents the market norm avoids that kind of disruption.

Level up

Leveling up to the M+C market norm reduces disruption to M+C beneficiaries. Unfortunately, moderating the effects of the demonstration on M+C beneficiaries would increase disruption for FFS beneficiaries. The reasoning here is straightforward. Enhancing the benefit package beyond the entitlement obviously increases the cost of the FFS bid and likely increases the amount by which (in high-payment sites) the FFS bid exceeds the government contribution. In a demonstration that includes FFS Medicare, such cost increases would result in increases in the out-of-pocket premium that all FFS Medicare beneficiaries would have to pay.

In addition, requiring FFS Medicare to offer a more generous benefit package in a demonstration project faces three other, important difficulties. First, it would be difficult for Medicare to price and administer such a benefit in a demonstration. If the FFS plan is required to offer benefits beyond the basic Medicare entitlement, HCFA would be forced to take on a new and difficult task as part of the demonstration. Outpatient prescription drug coverage would be especially challenging. HCFA has little operational experience with copayments, formularies, multi-tiered pricing for single-source versus multiple-source drugs, and drug utilization review programs. HCFA almost certainly would have to contract with the private sector to administer those benefits in a demonstration.

Second, enhancing FFS Medicare would have a serious effect on private Medigap coverage. If FFS Medicare is required to pay for extended hospital stays or outpatient prescription drug coverage, what happens to beneficiaries who already have that coverage through a private Medigap policy – one that perhaps is subsidized by their former employer? Should beneficiaries be told to drop those policies for the period of the demonstration with no guarantee that they will be able to re-enroll when the demonstration ends? If not, how should Medigap premiums be adjusted in the demonstration market areas to account for the fact that coverage under FFS Medicare has been expanded? Should Congress pass special legislation guaranteeing that beneficiaries can re-enroll under the terms of their original contracts? Will Medigap insurers that leave the demonstration area (because the enhanced benefit package replaces much of what they offer) return after the demonstration? Under what terms will returning companies issue policies to their former policy-holders?

Difficulties coordinating Medicare reform proposals with employment-based Medigap coverage was one of the factors that led to the repeal of the Medicare catastrophic coverage legislation in the late 1980s. That episode took place in the context of a national and supposedly permanent change in Medicare coverage. Coordination would be much more difficult in a local and temporary demonstration.

Third, if the FFS benefit package is enhanced, severe administrative difficulties would arise when residents of the demonstration site sought care in other locations, and when residents of other locations sought care within the demonstration site. In effect, HCFA would have to modify its entire claims payment system to pay for dual systems of FFS coverage and payment inside and outside the demonstration site:

- outside the demonstration area When demonstration FFS beneficiaries seek care in other locations, FFS providers would have to be: (a) made aware of the special enhanced package of benefits available to FFS beneficiaries under the demonstration and (b) be paid to provide those benefits, notwithstanding that Medicare ordinarily does not cover them.
- inside the demonstration area When FFS beneficiaries from other locations seek care in the demonstration area, providers would have to restrict coverage to the entitlement FFS package, notwithstanding that Medicare meanwhile covers additional services for the more numerous FFS beneficiaries living in the demonstration site.

HCFA could make these changes as part of a national Medicare reform effort, during which HCFA systems efforts and the attention of the entire provider community nationwide were focused on such changes. But these administrative tasks would be very difficult as part of a local demonstration.

Allow for different packages

The third alternative for designing the benefit package is to allow FFS Medicare to bid on the entitlement, while M+C plans bid on the enhanced benefit package. This alternative would preserve the notion of Medicare as an entitlement, as the government would purchase for FFS beneficiaries only those benefits to which they legally are entitled.

But this advantage comes at a cost. By having FFS bid on a different benefit package than M+C plans, the demonstration would fail to create a level playing field between the plans and FFS – that is, the demonstration would fail to establish the similarity in position that is one of the main reasons to include FFS in the first place. Two important questions arise. First, since the FFS bid is based on a different benefit package from M+C bids, how can the FFS bid be combined with the M+C bids to determine the government contribution to M+C and FFS? Second, what are the consequences of a high or low FFS bid, in comparison to M+C bids? The second question is addressed in Section 2.3.4, below. The first question admits to a reasonably practical, if partial, answer: analytic adjustments can be performed to make FFS and M+C bids roughly comparable, when the two sets of bids are based on different benefit packages. These analytic adjustments are not simple to

do (particularly given the quality of the M+C data available), but available data and methods should be sufficient to make the FFS bid "comparable enough" – sufficiently comparable so that, where large differences exist between FFS and M+C, those differences are reflected in the benefits and prices that FFS and M+C plans respectively can offer to beneficiaries.

The preferred demonstration option: allow for different packages

In view of all of the different considerations outlined above, the third alternative – allowing for different M+C and FFS benefit packages – appears to be the most practical approach to a demonstration. While this alternative fails to level the playing field between the M+C plans and FFS, there are limits to how level the field can be (see Section 2.3.5 below). And analytic adjustments can be performed to provide a workable basis for including FFS among the bids. In any event, the difficulties of this option are relatively minor, in comparison to the major administrative undertakings and fundamental Medigap complications that would follow from any effort to "level up" the FFS benefit for the brief period of a demonstration.

2.3.4 How should the government's contribution to premiums and beneficiaries' out-of-pocket premiums be determined?

The impact on beneficiaries of including FFS Medicare in the demonstration depends crucially on the way in which the government's contribution is set. Specifically, the government's contribution to premiums might be so arranged as to buffer the kinds of disruption FFS beneficiaries are likely to face.

CPAC had discretion over the rule for determining the government contribution, but CPAC's choices were constrained by the budget neutrality requirement. The primary concern was the per capita cost of M+C enrollees. Budget neutrality for those enrollees meant that the payment rules could not increase what the plans otherwise would have been paid by the government per M+C enrollee.

Many competitive pricing designs recommend setting the payer's contribution to premiums equal to the lowest bid submitted by a qualified plan. However, CPAC rejected this particular "level-dollar contribution" rule. This contribution rule would have minimized the government's costs in the demonstration. However, in the committee's judgment, this rule also would increase risks to quality of care, increase the number of beneficiaries disrupted by the demonstration (i.e., the number having to pay a premium), and increase the likelihood of low-ball pricing by some plans.

It is worth noting that most large employers that offer multiple health plans to their employees do not follow the level-dollar contribution rule (Feldman et al., 2000). Protection of FFS Medicare in the Competitive Pricing Demonstration simply is an extreme example of the same protection (i.e., higher employer premium contributions) that higher-priced health plans enjoy in most large, multiple health plan firms in the commercial sector (Dowd and Feldman, 1998). The Federal Employees Health Benefit Plan (FEHBP) follows a similar approach. FEHBP, which often is portrayed as a worthy model for Medicare reform (Butler

and Moffit, 1995), provides a seventy-five percent subsidy of the cost of high-priced health plans, up to a cap which few plans exceed.

Thus, in the demonstration, some differential subsidy of high-priced plans, including FFS, might be considered. The subsidy can come in the form of particular rules for setting the government contribution. There are many different ways to set the government's contribution to premiums. The main alternatives for protecting or subsidizing FFS are as follows:

- conduct the demonstration in a low-payment site, where FFS might be the low bidder,
- allow the FFS sector to bid on a less generous benefit package than M+C plans (a result that occurs naturally if FFS is excluded from the demonstration), or
- set the government contribution rule so that higher-priced plans, including FFS Medicare, are protected to some degree from having to charge higher out-of-pocket premiums.

The demonstration's budget neutrality constraint precluded the first option. CPAC, working under the budget neutrality constraint, implemented the second and third options. As noted in the previous section, by excluding FFS from demonstration bidding, CPAC in effect allowed FFS Medicare to bid on the entitlement, rather than the enhanced benefit package on which M+C plans bid.

Since CPAC did not include FFS Medicare in the demonstration, FFS beneficiaries were protected from the possibility of increased out-of-pocket premiums. But CPAC's premium contribution rules also protected some higher-priced M+C plans from charging out-of-pocket premiums, as well. Under the median bid contribution rule, half of all M+C plans in the market area would not have to charge an out-of-pocket premium. Under the weighted-average contribution rule, virtually all the M+C plans might escape charging an out-of-pocket premium if a large plan submitted a high bid. Indeed, given rules adopted in both demonstration sites to permit plans to waive notably small ("nuisance") premiums, the demonstration design in effect provided that if plan bids were clustered relatively close together, no plan would have to charge a premium.

If FFS Medicare is included in the bidding, the results change under the enrollment-weighted average rule, since FFS Medicare is the largest plan at most sites. If FFS Medicare is high priced, a FFS bid could result in most or all M+C plans being offered at zero premium, depending on the level of the enhanced benefit package on which M+C plans bid. That could happen even if the FFS sector bid only on the entitlement benefits. However, there are several problems with that approach. A premium contribution based on the enrollment-weighted average bid, including the price of the FFS sector, could increase the government's cost per beneficiary in FFS Medicare – a result forbidden by the budget neutrality constraint in the demonstration.

If the enrollment-weighted average bid (including the price of FFS Medicare) was less than the price of FFS Medicare, then beneficiaries in the FFS sector would face an increased out-of-pocket premium. If the enrollment-weighted average bid was greater than the price of FFS Medicare, then the budget neutrality constraint would supersede the bidding, and the government contribution to premiums would be limited to the current price of FFS Medicare, i.e., the status quo. In other words, including FFS Medicare in the calculation of the enrollment-weighted average bid in a demonstration project could produce only two results – one politically difficult (disruption of most FFS beneficiaries) and the other intrinsically uninteresting (the budget neutrality constraint supersedes the bidding). Partial inclusion of FFS, as under the CPAC design, avoided these problems. If FFS is included more completely, the issue of contribution rules will have to be revisited.

2.3.5 How "level" can the playing field be?

One of the main reasons to incorporate FFS in the demonstration is to create a level playing field between FFS and M+C alternatives. The underlying presumption is that, with Medicare policy not favoring one or the other (FFS or M+C), M+C plans would be treated more fairly.

It turns out, however, that the creation of a level playing field between FFS and M+C is difficult to accomplish. While FFS is not part of the direct competitive pressure of a competitive pricing system in this demonstration, FFS operates under many unique requirements that M+C plans do not face. For example, FFS is required:

- To forego many of the efficiencies utilized by managed care plans, such as exclusive contracting, targeting efficient care to high cost patients, and other techniques.
- To contract with all qualified providers in the demonstration area.
- To compensate professionals according to a common fee schedule, without any differences based on specialty, location, performance, or other criteria.
- To provide services in every county included in the demonstration.
- To forego prior authorization of services and other front-end utilization controls common in M+C plans.
- To serve end-stage renal disease beneficiaries in addition to aged and disabled beneficiaries.
- To provide explicit subsidies for graduate medical education and care for indigent patients.

FFS and M+C do not have to be equalized in every respect, to create workable provisions for including FFS and M+C in the same demonstration. The point is that

arguments about a level playing field, typically used to support the inclusion of FFS in the demonstration, actually cut both ways. There should be some balance in how the demonstration serves this objective. In particular, the demonstration should recognize that the two different sectors are supposed to be different. A demonstration should not require changes to level all these differences. Instead, the demonstration should take these differences into account when prices or bids from the two sectors are compared. As with benefit packages, discussed earlier (Section 2.3.3 above), it is important to allow differences between FFS and M+C plans, but to take account of those differences (notably, by analytically adjusting the FFS bid) to permit prices from the two sectors to be compared, without extreme or unnecessary changes to FFS or M+C.

2.4 Summary and possible changes in demonstration design

The discussion presented in this chapter can be summarized as follows:

- CPAC designed the demonstration subject to a series of important constraints, including the absence of any legal sanction for including FFS, the requirement of budget neutrality, and the simple fact that the demonstration was a demonstration, not a national reform. There are, as a result, compelling legal and political difficulties and design problems that argue against complete inclusion of FFS Medicare in a demonstration of competitive pricing, at the initial sites and in the initial years of the demonstration.
- The inclusion of FFS in the demonstration is not an all or nothing choice. There are many different methods and degrees of including FFS, so demonstration designers in principle have some flexibility in how they incorporate FFS. At one limit, FFS would be treated like any other health plan there would be a FFS bid, along with the bids of M+C plans. This relatively complete form of inclusion would require explicit Congressional authorization. It would also require special efforts to address the likely political problems of including the large group of FFS beneficiaries who have been protected from the effects of the demonstration to date.
- The most important considerations and challenges to the complete inclusion of FFS are as follows:
 - The protection of FFS can readily be done through careful structuring of demonstration design parameters, particularly the rules for determining the government contribution. Meanwhile, the "protection" of FFS Medicare in a M+C-only demonstration needs to be put in perspective. There are very few competitive settings (including such models for Medicare as FEHBP) that feature a truly level playing field for all health plans. Protection of FFS Medicare in the Competitive Pricing Demonstration simply is an extreme example of the same protection (i.e., higher employer premium contributions)

that higher-priced health plans enjoy in most large, multiple health plan firms in the commercial sector.

- Medicare should take manageable and feasible steps to test competitive pricing – e.g., starting with M+C plans – before trying to add FFS Medicare as a bidding health plan. CPAC's demonstration design was both manageable and feasible.
- Including FFS in a demonstration would be administratively difficult in many unique respects – most of them soluble with sufficient effort, but some of them (e.g., out-of-area care for demonstration-area FFS enrollees) extremely difficult to resolve.
- A M+C-only demonstration would be a valuable contribution to discussions of national Medicare reforms. Subsidies for high-cost plans such as FFS reduce, but do not eliminate, the incentive for plans to bid low. Meanwhile, plans could offer premium rebates to beneficiaries and thereby reduce the price of M+C below the Part B premium that FFS enrollees still would pay. This feature made a form of price competition between M+C plans and FFS possible. FFS was not entirely insulated from price competition as a result.
- Leveling the playing field between FFS Medicare and M+C plans is not feasible in a demonstration. FFS and M+C plans operate under different constraints, and a demonstration should take those differences into account when comparing bids, but not attempt to eliminate those differences, especially for the brief period of a demonstration.
- In later years of the demonstration, FFS could be included in the demonstration more completely. There are a number of important challenges to doing this - e.g., specifying the appropriate benefit package for FFS and deciding how the government contribution to premiums should be determined from the bids of M+C plans and FFS. But three things in particular would be required. First, complete incorporation of FFS would require an explicit mandate from Congress, as noted. Second, it would require some flexibility (e.g., with respect to budget neutrality) to enable CPAC to work through the extended array of design problems and political difficulties that incorporating FFS presents. Third, it would require full implementation of a reliable riskadjustment system to ensure that premium differentials among competing plans (including FFS Medicare) reflected differences in efficiency, rather than differences in the risk of the enrolled populations. In any event, the difficulties of including FFS Medicare in a demonstration project do not imply that FFS Medicare cannot be included in a national Medicare reform effort based on competitive pricing.

If the above reasons argue for postponing the complete inclusion of FFS until later in the demonstration, the question remains as to what can be done to facilitate complete inclusion of FFS. The CPAC can offer some suggestions that might ease this process, although there are no easy answers.

2.4.1 Ensure that the FFS bid is less than the government contribution to premiums

In principle, the only way to include FFS Medicare in a Competitive Pricing Demonstration and guarantee that out-of-pocket premiums for FFS Medicare will not increase is to ensure, somehow, that the bid submitted by FFS Medicare is no greater than the government's contribution to premiums. Although this strategy produces results that are equivalent to the full protection that FFS Medicare receives today, the protection could be somewhat less explicit. There are two ways that could happen:

- 1. The demonstration could be limited to low-payment sites in which all M+C plans (if there are any) currently charge a premium for basic Medicare benefits. In Minneapolis, for example, all M+C plans charge a premium for benefits that do not much exceed the entitlement, suggesting that FFS Medicare might be the low bidder in Minneapolis. CPAC saw little value in that type of demonstration, unless the standard benefit package on which all plans bid could be enhanced to include the basic minimum benefits typical of employment-based health insurance in particular, some level of outpatient prescription drug coverage. In any event, budget neutrality requirements prevented the CPAC from considering this option.
- 2. The government contribution to premiums could be increased as much as necessary to ensure that FFS Medicare was a "free" plan (i.e., available for no more than the current Part B premium). Evaluation of this rule depends on what benefit package FFS Medicare is required to offer. If FFS Medicare continues to offer only the basic entitlement benefits, then in high payment areas, this rule would produce the status quo, i.e., the government's contribution to premiums would approximate the current Medicare payment rate. Plans would continue to offer generous supplementary benefits at zero premium. If, on the other hand, FFS Medicare was required to offer the same enhanced benefit package on which M+C plans were required to bid (a very complicated option, for reasons noted earlier), the government's cost would be much higher than current spending levels and the demonstration would violate the "budget neutrality" constraint.

The important point to make here is that the "playing field" can be leveled in degrees, and more moderate degrees might be desirable. Thus, it might be desirable to change the site selection, benefit, or contribution rules so as to moderate the effects that otherwise would occur.

2.4.2 Lump-sum payments to hold the <u>demonstration area</u> harmless

A more general way to protect beneficiaries in demonstration areas would be to return any savings produced by the demonstration to beneficiaries living in the demonstration site. If the demonstration produced savings of \$10 million dollars relative to current payment policy, for example, and there were 10,000 beneficiaries in the demonstration site, then each beneficiary would be given \$1,000. 19 This approach does not hold harmless all beneficiaries who choose FFS Medicare. In some cases, their out-ofpocket premiums might increase more than this side payment. It does, however, hold harmless the demonstration site as a whole. In other words, the flow of federal funds into the demonstration site would not be diminished. The AACs in Phoenix and Kansas City were concerned that the demonstration might reduce federal funds flowing into their areas. They were particularly concerned that funds might be taken from their area and redistributed to low-payment areas. Accordingly, they chose a government premium contribution rule that they believed would maximize the flow of federal funds into their area (i.e., the higher of the median bid or the enrollment-weighted average bid). They also elicited from HCFA a commitment to consider arrangements to channel any savings from the demonstration back into the demonstration area (e.g., through quality incentive pools, as described in Chapter 3).

The practical difficulty with this "share the savings" approach is that, in a budgetneutral demonstration, rebates cannot be distributed until after the money is saved. Thus, no savings would be available for the first year of the demonstration, at a time when beneficiaries faced increased out-of-pocket costs for FFS Medicare, with no guarantee of a reward. The absence of any savings at this key startup point could be crippling: the demonstration would face intense political obstacles just as the demonstration was beginning to be implemented, without any side payments to compensate and moderate the opposition. This would be another version of the same political problem that has thwarted the M+C-only demonstration in each attempt to date – exacerbated, perhaps, by the fact that including FFS creates a much larger number of beneficiaries opposed to the demonstration at most sites.

2.4.3 Lump-sum payments and a suspension of budget neutrality to hold <u>beneficiaries</u> harmless from financial impacts of the demonstration

If new funds are allocated to the demonstration, it would be possible to make lump sum payments to beneficiaries that would offset the financial harm they would suffer under a demonstration that included FFS Medicare. As noted in Chapter 1, there is a precedent for making such payments to demonstration subjects. During the 1970s, the federal government funded a study of the relationship between health insurance benefits, health care spending, and health outcomes (the Health Insurance Experiment, or HIE). In that study, families were paid their maximum potential loss under the demonstration. Because the payment was a lump sum payment and could be used for any purpose, the payment did not enter the

January 19, 2001 Page 42

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¹⁹ It would be best to give a uniform "rebate" to all beneficiaries, rather than targeting beneficiaries in FFS Medicare or M+C plans. Competitive bidding is designed to remove distortions in the price of health plans faced by beneficiaries. Giving rebates based on the beneficiary's choice of health plan would introduce a new price distortion.

families' decisions to consume medical care. Thus, the payment managed to insulate beneficiaries from financial harm, but did so in a way that did not distort the study's results.

If the budget neutrality constraint could be waived, a similar lump sum payment could be made to all beneficiaries in a Competitive Pricing Demonstration site, to offset their possible financial losses and to hold them harmless from being selected as a test site for a demonstration that is critical to the future of Medicare. The payment would have to be equal to the estimated maximum out-of-pocket premium of any health plan, including FFS Medicare. The payment would need to go to all beneficiaries, not just those who chose a particular health plan. The estimated maximum out-of-pocket premium could be reduced by providing an explicit subsidy of higher-priced plans. A level percentage contribution to premium, similar to that of FEHBP, would be one way to reduce the maximum possible out-of-pocket premium.

²⁰ Payments based on the beneficiary's choice of health plan would distort beneficiaries choices of health plans by changing the relative premiums of health plans. Distortion of premiums was not an issue in the Health Insurance Experiment because families did not choose which plan to join. They were assigned randomly to different plans.

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Chapter 3.

The Nature and Extent of Quality Monitoring Activities

3.0 Introduction

From the first meeting of the CPAC, the committee made clear that it was interested in having competitive pricing do more than simply rationalize Medicare+Choice (M+C) payment amounts. Instead, the committee wanted to consider ways to join the incentives of competitive pricing to measures of quality, so that the demonstration could address issues of health care value, not just the level of Medicare prices. The committee wanted to explore the different ways that positive steps might be taken to incorporate quality goals in the Medicare payment methodology.

The committee concluded after a series of briefings from innovative health care programs and from quality experts at HCFA that:

- Quality reporting by M+C plans in the demonstration should be the same as the reporting requirements these plans ordinarily face.
- Quality innovations under consideration notably, the use of quality incentive pools as part of the payment system – should be based on measures of quality already being collected.

One major reason for these decisions was the need to minimize additional reporting burdens on demonstration health plans, given all the other things being asked of them. The only additional quality monitoring efforts envisioned for the demonstration were to be undertaken by HCFA at its expense, not by M+C plans.

Thus, the Competitive Pricing Demonstration posed essentially no new quality reporting and quality monitoring burdens for M+C plans. But CPAC remained interested in working with experts, the health plans, and others to consider how Medicare might better incorporate quality methods in its pricing requirements.

In Section 533 of the Balanced Budget Refinement Act of 1999, Congress required CPAC to submit a report on the following:

Quality Activities – The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original Medicare fee-for-service program generally.

CPAC sees three key questions in the Congressional requirement:

- 1. What is the nature and extent of the quality reporting and monitoring requirements imposed on M+C plans in the demonstration?
- 2. What costs will plans incur to satisfy those requirements?
- 3. What is HCFA's current ability to collect and report data to support comparable quality monitoring and reporting activities in fee-for-service (FFS) Medicare?

This chapter will address each of these questions, in turn. First, however, it will be useful to consider some background information on current M+C and FFS quality reporting requirements, before considering the special reporting and monitoring requirements of the demonstration, the costs of those requirements, and the possibility of comparable monitoring and reporting in Medicare FFS.

3.1 Background: current quality reporting and monitoring requirements for M+C plans and FFS providers

M+C plans have a fairly detailed set of reporting and monitoring requirements for quality. The requirements of FFS are more varied, for reasons having largely to do with certain intrinsic difficulties of FFS reporting, which will be discussed below. Our discussion below will focus on information that M+C and FFS providers report to the federal government in connection with the Medicare program, after they become qualified to provide Medicare-covered services. This restriction is not being made to minimize the significance of other quality reporting requirements – e.g., the requirements that state governments impose – but rather to permit some focus on the demonstration-related issues at the center of Congress' question to CPAC.²¹

We begin by reviewing the demands placed on M+C organizations, then provide a brief summary of data collection efforts in FFS. For both managed care and FFS

²¹ Following the language in the Congressional mandate for this report, we focus primarily on data that are collected explicitly to monitor quality. This approach understates the total data collection burden on both M+C plans and the FFS sector. M+C plans are required to report a great deal of data to the federal government that is not used to assess quality (e.g., the increasing quantities of encounter data Medicare will use to support refined risk-adjustment methods for determining M+C payments). Similarly FFS Medicare collects an enormous amount of data that is used primarily to pay providers, but also is used by researchers inside and outside of HCFA to assess quality in FFS Medicare. In fact, the use of Medicare administrative data of all kinds in HCFA-funded and other studies of quality and quality-related concerns constitutes one of the most important single ways we know about the quality of *any health services*, Medicare or otherwise. More specifically, the best information we have about the quality of care in FFS versus managed care comes from research on the Medicare program (much of it funded by HCFA). Nevertheless, while these administrative data requirements are surely part of what providers mean by the "burden of doing business with Medicare" and are certainly one of the ways we know about health care quality, they are not considered here in the context of quality reporting and monitoring in the competitive pricing demonstration.

organizations, quality-related data collection is an area of significant HCFA activity. The committee will note some of the most imminent HCFA developments, but it is fair to say that the picture provided in this paper is a snapshot that will be rendered somewhat obsolete even in the short timeframe now envisioned for the competitive pricing demonstration (e.g., 2002 and beyond).

3.1.1 Quality monitoring of Medicare+Choice organizations

Exhibit 3.1 below provides a summary of the principal quality-related data collection and monitoring demands placed on M+C organizations.

Exhibit 3.1. Medicare+Choice Organizations: Principal Quality-Related Reporting Requirements, 2000 Contract Year

Reporting Requirement	Sampling Frame/Period	Minimum Sample Size	Financial Responsibility	Due Dates	Similar data available from FFS?
HEDIS 2000 and HEDIS 2000 audit	Services delivered in 1999 (and earlier for some measures)	Measure-specific (MCOs must report all HCFA-required Medicare measures according to instructions)	MCO pays for external HEDIS Audit	MCO must submit Audited Summary and Patient- Level Data by June 30, 2000	No – methodologies currently being explored*
CAHPS	Members continuously enrolled 6 months prior to administration of survey	600 (If less than 600 enrollees, all members must be surveyed)	HCFA pays for survey administration	HCFA will administer survey in Fall 2000	No
Health Outcomes Survey	Members continuously enrolled 6 months prior to administration of survey	1000 (If less than 1000 enrollees, all members must be surveyed)	MCO pays for NCQA-certified vendor to administer survey	MCO must contract with NCQA- certified vendor before 2/24/2000	No

^{*} For example, a HCFA report on quality measurement in FFS finds it analytically feasible to develop performance measures for FFS, but the development of such methodologies is viewed as "extremely challenging." See HCFA, "Research and Analytic Support for Implementing Performance Measurement in Medicare Fee-for-Service," Second Annual Report, posted on HCFA's Quality of Care Home Page www.hcfa.gov/quality (February 28, 2000). SOURCE: Health Care Financing Administration, 2000.

1. Health Plan Employer Data and Information Set (HEDIS) – HEDIS is a set of standardized performance measures designed to assess the quality of health care and services provided by managed care plans. It is a common data collection instrument that HCFA has adopted for its own use in monitoring plans. It was developed by the National Committee for Quality Assurance (NCQA) to provide purchasers and consumers with the ability to evaluate the quality of different health plans and to make their plan decisions based upon demonstrated value rather than simply on cost.

These data ordinarily are required to be reported at the contract level ("H" number) – i.e., basically, at the service area level, except where the service area has been divided into market areas. However, HCFA can determine that the contract area should be subdivided into separate market areas, with the data reported accordingly. Before the data are submitted to HCFA, M+C organizations must obtain (at their own expense) a full external audit of the measures by an NCQA-qualified firm (this is, as it were, quality control on the quality control measures). HEDIS data requirements are common in the industry (e.g., private payers often require reporting of HEDIS data).

- 2. <u>Consumer Assessment of Health Plans Survey (CAHPS)</u> CAHPS is a widely used, standardized survey of beneficiary satisfaction. In Medicare, HCFA requires M+C Plans to participate annually in a survey of 600 or more of their beneficiaries using the CAHPS instrument. The survey is done at HCFA's expense.
 - In addition, in 2000, HCFA will begin reporting disenrollment rates, as required under the Balanced Budget Act of 1997. HCFA also will begin nationwide administration of the Medicare CAHPS Disenrollment Survey (at HCFA's expense).
- 3. <u>Health Outcomes Survey (HOS)</u> HOS is a survey-based measurement that monitors the functional status of managed care patients. 1,000 participants are chosen per M+C contract. They are surveyed every 2 years at plan expense, to assess the changes in their functional status. This quality improvement tool presents an aggregate overview of the baseline health status of each MCO's Medicare enrollees. State Peer Review Organizations/Quality Improvement Organizations (PRO/QIO) also receive copies of the performance profiles and are tasked to collaborate with MCOs, on request, to interpret the data; to identify opportunities to improve care; to assist MCOs in planning effective, measurable interventions; and to evaluate and monitor the results of interventions.

To understand the significance of the data HCFA collects, it is important to understand how HCFA is using these data. HCFA makes summary, plan-level performance measures available to the public through media that are beneficiary oriented, such as the *Medicare Compare* Internet site (www.medicare.gov) and the *Medicare & You* handbook. A subset of HEDIS and CAHPS data is also available for distribution in printed form through a toll free line (1-800-MEDICARE). The complete HEDIS summary data files received will be available through HCFA's Internet website as a Public Use File (www.hcfa.gov). The HEDIS, CAHPS, and Disenrollment Survey patient-level files will be available at cost to requesters authorized to receive such information, subject to certain confidentiality restrictions.

The above data collection requirements need to be understood in the context of a larger HCFA effort to improve quality in Medicare and Medicaid: the Quality Improvement System for Managed Care (QISMC). QISMC is a HCFA initiative to strengthen managed care organizations' efforts to protect and improve the health and satisfaction of Medicare and Medicaid enrollees. QISMC standards and guidelines are key tools for use by HCFA

(and states) in implementing the quality assurance provisions of the Balanced Budget Act of 1997 (BBA). QISMC is designed:

- To develop a coordinated Medicare and Medicaid quality oversight system that would reduce duplicate or conflicting efforts and send a uniform message on quality to organizations and consumers.
- To make the most effective use of available quality measurement and improvement tools, while allowing sufficient flexibility to incorporate new developments in the rapidly advancing state of the art.

For Medicare, QISMC represents HCFA's administrative interpretation of the Medicare+Choice requirements relating to an organization's operation and performance in the areas of quality measurement and improvement and the delivery of health care and enrollee services. For Medicare+Choice organizations, the QISMC standards took effect on January 1, 1999. During the first contract year, organizations were required to report on HEDIS and CAHPS measures, but they did not have to meet any minimum performance levels. They were, however, required to initiate two performance improvement projects (a significant reduction from the seven projects proposed in the original QISMC draft). Neither project was required to achieve demonstrable improvement until the end of the third contract year, i.e., 2001. By the end of the first contract year, it was only necessary for projects to have advanced to the point of topic identification, performance indicator selection, and baseline data collection. The important point to note here, then, is that HCFA is just starting to use quality-related information in the context of a continuous quality improvement process, QISMC.

A final area of data collection from M+C plans is encounter data. To support major refinements in risk adjustment methods required by the BBA, M+C plans are required to provide encounter data across an increasing scope of their services. These requirements reflect a major data collection effort by M+C plans, beginning in 1998 with the submission of hospital inpatient encounters to HCFA. Submission of physician encounters is scheduled to begin in October 2000, and hospital outpatient encounters in January 2001. In due course, the availability of M+C encounter information may permit analyses of aspects of quality in the Medicare managed care that were not possible before.

Thus, at present, data collection efforts from M+C plans are focused on HEDIS, CAHPS, and HOS, with recent steps to include disenrollment information as required by BBA. This information is beginning to be more fully exploited, through publication of comparative results (e.g., on HEDIS measures) as well as through quality-improvement processes like QISMC. HCFA will be collecting appeals and grievance data from MCOs in the near future, but does not do so now. The availability of encounter data of increasing scope will permit new analyses of M+C quality to be performed.

3.1.2 Quality-related data collection from fee-for-service providers

FFS Medicare involves one major form of data collection and reporting that is intrinsic to what it means to be "fee-for-service": the submission of claims for reimbursement of services. These claims are subject to detailed requirements and constitute a major data collection effort for providers in FFS, analogous to the encounter data now being required of M+C plans. Like the encounter data, FFS claims are not quality reporting documents, but much that we know about Medicare quality has been learned from such administrative records. The data collected through administrative claims are used to determine the structure and processes of care delivered at the visit/stay level rather than outcomes of care. To date, FFS providers have not been required to report outcome-oriented information.

Given the diverse array of different types of FFS providers, it is impractical to provide detailed descriptions of data collection efforts from each of them. A few general points can be made, however (see Exhibit 3.2 below for a summary). First, current quality monitoring of FFS providers is minimal compared to M+C organizations. Second, FFS monitoring as it currently exists reflects a variety of different approaches. For example:

- Annual survey and certification by (usually) state surveyors of nursing homes and home health agencies Each year, state surveyors visit home health agencies and nursing homes, as agents of the Medicare and Medicaid programs. These surveys are designed to ensure compliance with minimum Medicare and Medicaid requirements.
- Cooperation with PRO review of medical records When PROs establish a sample of patients or beneficiaries for study purposes, hospitals and other institutions are required to cooperate in providing medical and other records. Obviously, this is a minor intrusion.
- Provision of a minimum data set (MDS) by nursing homes and of the Outcome Assessment Information Set (OASIS) by home health agencies Nursing homes and home health agencies come closest to managed care organizations in their data requirements, in that they are now required to submit quarterly various forms of standardized data sets. OASIS, for example, includes sociodemographic, environmental, support system, health status, and functional status attributes of adult (non-maternity) patients treated by home health agencies.

HCFA plans to report such data to the public in a comparative fashion, much as it has done with HEDIS and other M+C data. For example, HCFA has set up a Nursing Home Database to "provide understandable information about the performance of every Medicare and Medicaid certified nursing home in the country," based on information from the MDS and other sources.

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²² The quote is from the "Nursing Home Compare" web page in www.hcfa.gov.

Exhibit 3.2. Medicare Fee-for-Service: Quality-Related Monitoring Activities and Initiatives

		Deta	
Provider	Initiative	Data Collection Instrument	Current Status
ESRD	End Stage Renal Disease (ESRD) Quality Improvement Initiative: The BBA directed the development of a method to measure quality of services in renal dialysis facilities. Sixteen Clinical Performance Measures (CPMs) were developed and pilot-tested in 1999. The collection of the CPMs on a national sample of dialysis patients will be implemented in 2000; facility-specific collection is anticipated to begin in 2001.	ESRD Clinical Performance Measures	Required
PHYSICIANS	HER Contract on Performance Measurement in Fee-for-Service: HCFA is testing the feasibility of using measures in FFS at the national, small geographic, and large group practice level (1997-2000). The Medicare Health Outcomes Survey (for M+C plans) is also being pilottested in this project.	Subset of HEDIS	Under development
HOSPITALS	PRO Projects such as the Cooperative Cardiovascular Project, have utilized a standardized set of performance measures to evaluate quality improvement initiatives on a population basis. Six national clinical priorities have been established for the 6th Scope of Work (SOW) for the PROs, four of which primarily involve inpatient quality measures. Using administrative claims data to identify cases, a sample of hospital charts will be abstracted in each state and evaluated for performance on the established measures.	MEDQUEST	Required for PRO Program
	Hospital Core Performance Measure Set: HCFA is exploring the concept of requiring Medicare participating hospitals to report on a national standardized set of performance measures. HCFA will work with the State of Rhode Island and the National Forum for Health Care Quality Measurement and Reporting, hospital associations, and accrediting organizations to standardize a core set of hospital performance measures. During this initial stage, for example, HCFA has available (through the PRO Program) performance measures for pneumonia, heart failure, stroke and myocardial infarction to offer as a starting point to initiate this effort.	To be developed	Under development
NURSING HOMES/ SKILLED NURSING FACILITIES	Quality Indicators for Nursing Homes: All certified long term care facilities were required to transmit their minimum dataset (MDS) records to their states (and states to HCFA) as of June 22, 1998. Facilities may use RAVEN, a HCFA product, or a privately developed software product that meets RAVEN's specifications, to capture and transmit the MDS data. Information based on the MDS will begin to be used to focus the long-term care survey process as of July 1, 1999, and facility- and resident-level quality improvement (QI) reports will be available to the facility about that time. HCFA is also in the process of developing and testing additional quality indicators for LTC and post-acute settings.	MDS transmission using RAVEN specifications	Required (1990) Required (6/22/98)

Exhibit 3.2. FFS Quality-Related Monitoring Activities and Initiatives [continued]

Provider	Initiative	Data Collection Instrument	Current Status
ННА	OASIS/OBQI: HCFA developed the Outcome Assessment Information Set (OASIS) system, which is a clinical data set designed specifically to develop outcome-based quality indicators (OBQI) for home health care. HCFA is currently sponsoring a major demonstration project to test OBQIs for use in quality improvement and, it is anticipated, for survey and certification.	OASIS	Required
	OASIS/OBQI – HAVEN: In order to encode/capture data, HHAs may use a HCFA product, HAVEN, or any privately developed software that meets HAVEN specifications, to capture and transmit the data. HAVEN provides common specifications that can be used in any software tool. Outcome reports will be generated by the state agency based on patient-level data, providing feedback to the HHA which will stimulate quality improvement projects.	OASIS data transmission using HAVEN specifications	Required for all Medicare and Medicaid Skilled Care Patients (1999 – 2000 implementation)
OUTPATIENT	In the PRO 6th Scope of Work, administrative claims data will be used to evaluate state-specific performance on delivery of influenza immunizations, pneumococcal polysaccharide vaccinations, mammograms, and care for people with diabetes, in the outpatient setting among the fee-for-service population.	Claims-based (MEDQUEST for Diabetes)	Required for PRO Program Rates available prior to beginning 6th SoW
GENERAL BENEFICIARY- BASED MEASURES	Population-Based Surveys: Under this effort, an annual, standard, list-based telesurvey will be conducted at the state level on health status, risk factors, and receipt of preventive services. Under the 6th SOW, as well as GPRA and NPR, there are many Quality Indicators that must be monitored to ensure achievement of HCFA's and the PRO's mission in the outpatient setting. Standardization of survey instruments and data collection methods will allow HCFA to implement any required system changes due to new or revised program initiatives centrally, uniformly, and in a timely manner.	Medicare Quality Monitoring System (MQMS) Telesurvey	Under development
	Consumer Assessment of Health Plans Survey (CAHPS) for FFS: The Medicare CAHPS-FFS Survey collects information from FFS beneficiaries about their experiences and satisfaction with health care services under Medicare.	Medicare CAHPS- FFS Survey	BBA requirement. Data collection to begin Fall 2000

SOURCE: "HCFA Quality of Care Information: Project Activities," updated March 1, 2000 (from wwww.HCFA.gov).

Third, FFS data collection requirements are increasing. HCFA is actively developing a variety of new quality-monitoring tools for application to FFS providers, such as FFS versions of HOS and CAHPS (see Exhibit 3.2). The future application of these developing tools is uncertain, but all knowledgeable observers expect FFS tools to increase in their extent and sophistication.

3.2 The Competitive Pricing Demonstration: content and cost of added reporting and monitoring requirements for M+C plans

The discussion to this point outlines the basic reporting requirements faced by M+C plans in conventional, non-demonstration settings. The question then becomes the question asked by Congress of the CPAC: what is the nature and extent of additional quality reporting and monitoring requirements imposed on M+C plans in the demonstration?

3.2.1 Basic monitoring and reporting requirements

In CPAC's view, the first, and most important, quality protection for the Competitive Pricing Demonstration is HCFA's health plan qualification process. The CPAC design did not allow non-Medicare-qualified plans to participate in the demonstration. If the qualification process works well, health plans offering poor quality of care are not offered to beneficiaries at all. Beyond this basic rule, however, CPAC sought to design an explicit system of rewards for health plans that offer higher quality care. As noted in the committee's Design Report in early 1999:

CPAC RECOMMENDATION: HCFA generally should follow current Medicare practice for the early years of the demonstration – specifically, HCFA should rely on the plan qualification process and retail competition among plans (and should consider using existing accreditation agencies such as NCQA or JCAHO) to ensure the quality of care of health plans. In addition, HCFA should provide the CPAC with more information on what measures are available to use in measuring plan quality of care, and how these measures could be used in the out years of the demonstration to create an incentive pool for high quality plans (e.g., by withholding a small percentage of savings to create the pool and distributing it among plans, based on the achievement of quality goals).

Thus, CPAC made it clear that the issue of quality incentives was an open issue, with regard to the later years of the demonstration. But M+C quality reporting and monitoring requirements were to be unchanged from non-demonstration requirements. Even in later years, when incentive pools might be created, these arrangements were to be based on "available" measures.

3.2.2 Quality incentive pools

In its first meeting in May 1998 and consistently in meetings thereafter, the CPAC made clear that it was interested in having competitive pricing do more than simply

January 19, 2001 Page 53

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²³ See Competitive Pricing Advisory Committee, "Design Report of the Competitive Pricing Advisory Committee," January 6, 1999, p. 12.

rationalize Medicare+Choice (M+C) payment amounts. Instead, the committee wanted to consider ways to join the incentives of competitive pricing to measures of quality, to attempt to incorporate quality goals in the Medicare payment methodology. Following briefings by HCFA experts and reviews of the state-of-the-art among public and private health benefit programs, the committee tentatively decided that the most practical way to incorporate quality goals in the Competitive Pricing Demonstration was through quality incentive pools. As noted in the committee's recommendation quoted above, quality incentive pools basically involve withholding a small percentage of savings to create an incentive pool, then distributing that pool among plans, based on their relative levels of achievement of specified quality goals. These incentive pools were expected to bring an enhanced focus on quality goals among plans, thereby potentially enhancing the contribution that the demonstration could make. These pools had an additional virtue that became clear later in the demonstration. As the Kansas City and Phoenix AACs continued their implementation work, they sought reassurances from HCFA that the demonstration would not simply take money from their communities – i.e., that savings in reimbursement would not go to other communities or to the U.S. Treasury, but instead would be reinvested in the demonstration HCFA pledged to consider arrangements to that end. Quality incentive pools presented a practical and productive way for HCFA to make good on that reassurance.

At its meeting in October 1999, the CPAC spelled out its guidelines for quality incentive pools. The six guidelines were as follows:

- 1. Quality incentive pool elements should be recommended by the AACs, approved by the CPAC, and forwarded to HCFA for consideration;
- 2. The quality incentive pools need not be the same for each demonstration site;
- 3. Demonstration activities should not require new quality indicators;
- 4. [Quality incentive pools should] Encourage the selection of quality indicators that are reliable and valid and are currently being audited (or are planned to be audited) for accuracy;
- 5. Pools should be established such that rewards should be split between health plans and providers according to guidelines set by the local AACs; and
- 6. Targets should be carefully set to create incentives that encourage significant, demonstrable, and sustained increases in quality beyond current requirements (e.g., those of HCFA and other purchasers).²⁴

Obviously, CPAC had ambitious quality incentive arrangements in mind. However, the committee again made explicit its judgment that this ambitious new incentive system was not to add to the administrative burdens plans faced, as the new arrangements would not require any "new quality indicators."

January 19, 2001 Page 54

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²⁴ These six points are quoted from the minutes of the CPAC Meeting of October 29, 1999. Emphasis added.

3.3 Answers to Congress' questions

In view of the discussion above, the answers to Congress' questions can be simply stated.. As to Congress' first question: under the initial CPAC design, and even under the quality incentive arrangements envisioned for later years of the demonstration, there were no additional quality monitoring and reporting requirements to be imposed on M+C plans.

This conclusion means that the second question Congress has asked also has a simple answer. The additional costs of the demonstration for quality reporting and monitoring by M+C plans were to be essentially zero. This is not to say that M+C plans do not face a substantial quality reporting burden. It is only to emphasize that the CPAC made special efforts to ensure that the demonstration did not threaten to add to that burden.

The final question Congress asked concerned HCFA's current ability to support FFS reporting activities comparable to M+C reporting activities. It should be clear from earlier discussion that FFS monitoring and reporting activities are expected to increase in the near future. Those increasing burdens are likely to reduce, somewhat at least, the current difference between FFS and M+C plans. For example, to carry out its requirement under the BBA to report comparable information to Medicare beneficiaries about the effectiveness of healthcare in their areas, HCFA has been overseeing a set of new analytic efforts to adapt quality performance measures to the FFS setting. These analytic efforts have sought practical steps toward more comprehensive quality reporting, while recognizing that FFS context poses unique challenges to what can be monitored. For example, by comparison to M+C organizations, FFS providers to the term of the term

- <u>have less control over beneficiary health status</u> FFS providers typically cannot monitor care provided outside their practice settings. They often must rely on patient recall.
- have patient groups that are not so clearly defined There is some question about when particular beneficiaries should be attributed to a FFS provider (e.g., an outpatient physician). Should such attribution occur when the physician or group practice provides more than half of the beneficiary's care? Some other proportion of the care?
- have less capable information systems and face structural barriers to combining information across practice or service settings For many FFS providers, internal information systems are less comprehensive and automated thus less useful for performing performance measurement than those commonly available in managed care organizations. Whatever a provider's capabilities on this score, particular providers are obviously limited in how they can combine information across service or practice settings, by comparison to managed care organizations.

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²⁵ E.g., see Health Economics Research, "Performance Measurement in Medicare FFS: Second Annual Report," report submitted to the Health Care Financing Administration, 1999.

²⁶ The following points comparing M+C and FFS quality reporting are adapted from Ibid.

may have different kind of patients, with different health-seeking behaviors—
It is possible that FFS beneficiaries have different health-seeking behaviors than managed care beneficiaries, with the potential to influence the rate of preventive service performance in FFS. More research is required to understand this problem.

Perhaps the main consideration to bear in mind in thinking about the differences in quality reporting and monitoring between Medicare+Choice and FFS is that these differences may have to narrow if FFS were to be incorporated into the Competitive Pricing Demonstration (see Chapter 2 above). Because of the inherent problems restraining comparability, the timing required to narrow these differences might not coincide with the timeframe of the demonstration initiative.

3.4 Other quality monitoring and reporting in the demonstration

One final point should be noted. Although the added burden on M+C plans for quality reporting and monitoring was not to be increased by the demonstration, that does not mean that the demonstration was not going to receive any special data collection or monitoring effort. HCFA developed plans for special monitoring and reporting efforts at its own expense to provide early detection of any demonstration problems. included: a) contracting with a special independent evaluator to collect and analyze data on demonstration effects, a common practice in demonstrations of this sort and required by the BBA in any event; b) as part of the bid evaluation process, HCFA planned to have technical assistance contractors analyze key indicators of beneficiary effects before the bidding results were announced (many of these indicators – e.g., the stability of primary care physician relationships – were to be monitored because of their relationships to quality of care.); and c) the HCFA Regional Offices were working with the plans and providers in Kansas City and Phoenix to discover, among other things, early indications of any problems. These examples reflect the virtues of a demonstration: in a small area, HCFA could devote extra efforts to the review and analysis of existing data and to the acquisition of additional information with no additional burden on the plans. Together, these efforts promised to provide early warning of possible, quality-related problems in the demonstration.

3.5 Conclusion

Since the beginning of its tenure, CPAC has sought to use the Competitive Pricing Demonstration to enhance the quality of Medicare-covered services, not simply to rationalize prices paid to M+C plans. But CPAC has also insisted from the beginning that M+C plans should not bear an extra burden of quality reporting or monitoring. Even in the out years of the demonstration, quality incentive pools or other quality-related ventures were required to work within existing quality measures. The only special quality monitoring was to come from HCFA, to provide early reports of any demonstration problems. As a result, CPAC concludes that the cost burden on plans for additional quality monitoring and reporting in the demonstration would be essentially zero.

HCFA continues to develop improved measures for monitoring FFS providers, but those measures vary considerably by provider type. Meanwhile, there are substantial technical and practical issues to resolve to adapt the quality reporting framework of M+C (or something like it) to the special problems of monitoring FFS. For the timeframe of the Competitive Pricing Demonstration, quality reporting by FFS providers is likely to remain different and less comprehensive than that routinely required of M+C plans.

Chapter 4.

A Rural Demonstration of Competitive Pricing in Medicare

4.0. Introduction

The Balanced Budget Act (BBA) of 1997 specifies that at least one of the Competitive Pricing Demonstration sites shall be a "rural" area. The Competitive Pricing Advisory Committee (CPAC) has given considerable thought to a rural demonstration project and foresees a number of important challenges. Some of those are conceptual in nature, while others represent technical barriers to implementation.

The conceptual difficulties arise from a lack of clarity in the goals and objectives for a rural demonstration project. The technical difficulties center on the budget neutrality constraint which the Demonstration must satisfy, ²⁷ and also on problems that are inherent to competitive systems in rural areas. During the site selection process, the CPAC emphasized choice of a site in a non-rural area. Recognizing the complications associated with rural site selection, the CPAC decided to defer selection of a rural site until later sites were chosen.

In Section 533 of the BBA Refinement Act of 1999, Congress directed the CPAC to report on the particular difficulties of a rural project – specifically, on:

The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project... and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

The committee provides its report on rural projects in this chapter. The chapter begins by discussing the ambiguities of the BBA mandate and then offers a statement of objectives that CPAC believes could be addressed by payment methods (competitive and other). The chapter then proceeds to consider payment alternatives and how a demonstration might feasibly be conducted in rural areas.

In the background throughout this discussion will be a set of premises about the character and needs of "rural" areas. To make those premises more explicit, the Appendix to this chapter provides background data on rural counties.

²⁷ The 1997 BBA legislation (Subchapter A, Section 4011g) stated that payments to Medicare+Choice organizations in the demonstration "for any designated area for a fiscal year" could not may not exceed the aggregate payments to such organizations that would have been made if the project had not been conducted. This language meant that the demonstration had to be budget neutral in each site in each year, a strict requirement

4.1. Problems with the BBA mandate

4.1.1. What is "rural"?

The first conceptual problem facing a rural demonstration of competitive pricing is the definition of "rural". The distinction between rural and urban areas generally is made at the county level. The most widely used definition of a rural county is a county that is not included in any metropolitan statistical area (MSA). This is the definition that we use throughout this report. This definition covers many different types of rural areas – from counties near large metropolitan areas to counties in the frontier – and different types of rural demonstration projects likely would apply to different types of rural areas.

4.1.2. What is the "problem" in rural areas?

Health care in rural areas faces a number of important challenges. Often, hospitals and health care providers are in short supply in rural counties. The population in many rural areas is not adequate to support private sector investment in health care facilities or the development of integrated health insurance and health care delivery systems such as health maintenance organizations (HMOs). Low population density results in a higher average cost of care. Rural health plans and providers do not enjoy the same economies of scale in production and administration as their counterparts in urban areas. The "economies of scale" problems in rural areas extend to other public services such as schools and the postal service. Interestingly, those other services often receive explicit subsidizes in rural areas, while Medicare services do not. In fact, payments for the care of rural residents under FFS Medicare often do not go to rural providers, because many rural residents prefer or are required to travel long distances to use urban providers.

In addition, residents of rural areas often have relatively low incomes, and cannot afford private supplements for their basic Medicare coverage, much less coverage for expensive "extras" such as outpatient prescription drugs. In Medicare, difficult access to health care services in some rural areas, including long travel times, translates into relatively low expenditures in fee-for-service (FFS) Medicare which, in the past, resulted in low payment rates for Medicare + Choice (M+C) plans. This "under-use" of service, if severe, can become a quality of care issue. Payment inequities are being addressed slowly through increases in the "floor" payments specified in the BBA legislation and through enhancements specified in the Balanced Budget Refinement Act of 1999, but participation in rural counties by Medicare+Choice (M+C) plans still remains very low (see Appendix).

Perhaps the most important reason to be concerned about rural areas, as well as low-payment urban areas, is the issue of fairness. Medicare is a national entitlement program. Taxpayers in all parts of the U.S. contribute to Medicare under a uniform set of rules. The benefit package specified in the FFS Medicare entitlement also is uniform nationwide. The introduction of capitated private health plans, first through the TEFRA-risk program and now through the M+C program, has created inequities in the level of government-financed benefits across areas. The 1997 BBA payment methodology is compressing the national

variation in payment rates, but there are no benchmark objectives or performance criteria to guide that process.

4.1.3. Can competitive pricing help?

Because of these problems, rural counties represent an essential focus for improved Medicare policy. The residents of rural areas are disproportionately older and could benefit from access to health care facilities and health insurance products designed to meet their needs. The question that CPAC addressed is "What role could competitive pricing play in meeting the needs of Medicare beneficiaries in rural areas?" The answer depends on the way in which the objectives for rural areas are framed.

Sometimes the objective for rural areas is framed as "expanded choices." Other times the objective is framed "adequate access to care." Other times the objective is "improved or equitable benefits." It is important to define the objective clearly, because doing so makes it possible to discuss what competitive pricing might, and might not, be able to accomplish in rural areas. If the objective of competitive pricing in rural areas is to expand choices or improve access to care or coverage levels, then it is important to understand that the primary barrier to those improvements is not lack of competition, per se, but lack of resources in rural areas.

Lack of resources includes lack of a population base, lack of health care providers, and – in some cases – beneficiary income levels that are insufficient to support coverage of services beyond the Medicare entitlement. Private firms will not invest or compete in areas where there are no rewards to investment or rewards for successful competitors. When health care providers are in relatively shortly supply, it is impossible to develop competing health care delivery systems that integrate payment and the provision of care.

Of course, rural counties are by no means homogenous. Not all rural U.S. counties are sparsely populated or low-income. There currently are some rural counties in which several M+C plans are offered to Medicare beneficiaries and a few counties even feature M+C plans with expanded supplementary benefits, including free prescription drug coverage in some cases.

CPAC could have designated one of these "urban-like" areas as a demonstration site. There are a number of difficulties with that strategy, however. "Urban-like" rural areas are not typical of all rural areas. It is not clear whether any of the lessons learned from a demonstration in one of those areas would be generalizable to (or address any of the recognized problems of) the majority of rural areas.

Another difficulty with that strategy is that competition among M+C plans in those areas appears to be fragile. Often there is a shortage of providers, let alone enough providers to form competing networks. M+C payment levels generally are low, and plan participation seems to be quite volatile. Most of the service area reductions in the M+C program from 1999 to 2000 were in rural areas. CPAC saw no reason to conduct the initial tests of competitive pricing in areas where competition was so vulnerable.

As a result, CPAC decided against choosing a rural site for one of the initial demonstration projects. CPAC remains interested in a rural demonstration of competitive pricing, however, as well as the problem of finding the proper level of M+C payment in rural counties.

4.2 An achievable objective

CPAC believes that an achievable purpose for the competitive pricing demonstration in general, and a rural demonstration in particular, is:

To determine if "modern" health plan payment methods and integrated health care delivery systems can improve the health care received by rural Medicare beneficiaries. Embedded within these goals is the necessity of finding the proper funding level to achieve these objectives.

A "modern" payment system would be one in which information about health plans' costs feeds back into the payment-setting process. Competitive pricing provides the most direct form of feedback, because M+C payments are a simple function of health plan bids (e.g., the median bid or enrollment-weighted average bid, as in the CPAC demonstration design). There is at least one other modern payment system, geographic capitation, that could be applied in rural areas. Geographic capitation is discussed below.

Integrated health care delivery systems combine the financing and delivery of health care services in ways that encourage provision of effective medical care. The potential for increased efficiency in integrated delivery systems drives much of the general interest in the M+C program. Due to the lack of M+C activity in rural areas, Medicare care providers in rural areas disproportionately are paid through traditional fee-for-service (FFS) insurance. There is no payment incentive for provision of efficient care. Integrated health care delivery systems, at their best, provide those incentives *and* the information systems needed to support the provision of effective medical care.

Some factors such as population density, supply of providers, availability of telemedicine, and receptivity to non-physician providers are not likely to be affected directly by a rural demonstration project. The supply of providers and technology may be addressed best through explicit subsidies to encourage that type of expenditure. But CPAC believes that the development of integrated delivery systems in rural areas, which might be facilitated by modernized M+C payment systems, has the potential to improve the quality of care received by rural residents. A rural demonstration also could address the important issue of nationwide fairness in government-financed benefits, as well. A rural demonstration of competitive pricing should facilitate the development of explicit performance criteria to be achieved in a rural demonstration, and test a payment system (i.e., a system in which plans provide cost data to the government) that is capable of achieving those objectives

4.3 Implementation

How could a rural demonstration of competitive pricing achieve the goals outlined above? The primary policy "levers" at the government's disposal are the amount and structure of payments to M+C plans and FFS Medicare providers. Would manipulation of either lever make a difference? There are several barriers that stand in the way of a successful demonstration. Some of the barriers were enumerated above. A subset of those barriers is likely to be quite intractable, and unaffected by government policy. The most obvious examples are low population density and, in the short run at least, a shortage of health care personnel in most rural areas.

The primary purpose of the competitive pricing demonstration is not to effect major structural changes in the health care delivery systems in rural areas, but rather to test a new way of finding the proper level of payment to M+C plans – recognizing that the proper payment level could encourage innovative improvements in the health care delivery system. It is conceivable that *some* barriers to improved care in rural areas, such as low participation by M+C plans, could be overcome by altering the level or structure of payments to M+C plans.

4.3.1. Altering the level of payment to M+C plans

Altering the level of payment to M+C plans means increasing payment levels above those specified in the 1997 BBA legislation. At present, the Demonstration's budget neutrality constraint precludes increases of that type. The 1997 BBA legislation prohibits the transfer of funds among demonstration sites, as well as the transfer of funds among years within a single demonstration site. That constraint makes it impossible to offer a positive incentive to a Demonstration site in the form of more generous benefits or lower out-of-pocket premiums (including the Part B premium) than would have prevailed in the absence of the Demonstration.

Are positive financial incentives essential to a successful demonstration of competitive pricing in a rural area? Examination of data from the M+C program suggests that high M+C payment levels are neither a necessary nor sufficient condition for M+C participation in rural counties. Note, for example, that in rural counties experiencing new entry by M+C plans in 2000, payment levels are relatively low. Only 3 of 87 counties experiencing "new entry" by M+C plans this year have payment levels over \$450 and 84 percent of these counties are rural counties (HCFA, 1999).

Although higher payments may be neither necessary nor sufficient to ensure M+C participation in rural areas, higher payments certainly are associated with increased M+C participation (Adamache and Rossiter, 1986). Higher payment levels might be able to

January 19, 2001 Page 62

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²⁸ In all areas of the country since July 1998, new Medicare contracts have been approved involving 42 managed care organizations and affecting 400,000 beneficiaries in 87 counties. Of the 400,000 beneficiaries, 200,000 are in rural areas. Of the 87 counties, 84 percent are in rural areas.

stabilize M+C plan participation in some rural areas where plans already are present. Higher payments also would allow plans to offer benefit packages that were more attractive to beneficiaries, creating a larger, and perhaps more stable, enrollment base for plans in those areas. Under the current budget neutrality constraint, however, higher payments are not an option that CPAC can consider.

4.3.2. Altering the <u>structure</u> of payments to M+C plans and FFS providers

The overall level of payments is not the only payment issue to be addressed in thinking about a competitive pricing demonstration in rural areas. The structure of payments – i.e., the process and rules for how plans get paid – matters as well. In their discussion of ways to modify the structure of payments to either M+C plans or FFS providers, CPAC identified five alternatives.

The structured Dutch auction

The first alternative is a form of competitive bidding that builds on current payment policy. M+C payment policy after the 1997 BBA legislation could be termed an "unstructured Dutch auction." In a Dutch auction, payments are increased until some desirable event takes place. That is approximately what is happening with payments to M+C plans in rural areas. Following the 1997 BBA legislation, M+C payments in low payment counties (most of which are rural) were subject to substantial rates of increase. Most of these lowest payment counties are rural counties. The BBA Refinement Act of 1999 promises to enlarge these increases further, by providing bonus increases of 5 percent for the first M+C plan to enter a county that has not been served by M+C plans since 1997. As a result, low-paid rural counties will be experiencing more rapid rates of payment increases; in principle, these increases could – at *some* point – yield improved participation by health plans in rural areas.

The reason that current Dutch auction is "unstructured" is because there is no monitoring mechanism in place; and no one has clearly defined *behavioral* criteria to define success (i.e., to define the stopping criteria for the increases). In a true Dutch auction, the stopping criteria should reflect health plan behavior, e.g., the entry of two M+C plans into a county, or the enhancement of benefits to specific levels of coverage at specific out-of-pocket premiums. Arbitrary legislative deadlines for premium increases do not constitute "structure" for this type of bidding process. The first way to alter the structure of M+C payments in rural areas is to convert current payment policy to a *structured* Dutch auction, with explicit goals and health plan behavioral criteria governing adjustments to payment levels.

Bidding with one winner

Under current M+C payment policy, any qualified M+C plan can participate in Medicare. It is possible that in some sparsely populated areas, M+C plans are reluctant to

²⁹ The bonus is 5 percent in the first year the plan enters the county, and 3 percent in the subsequent year.

enter because they fear that their entry would spark the interest of rival health plans, and the population base may not be sufficiently large to support multiple M+C plans in the market. Because withdrawal from a county is a traumatic experience both for health plans and beneficiaries, health plans may be reluctant to enter these "marginal" rural counties.

Under the one-winner proposal, CPAC would define a standard benefit package and M+C plans would submit bids on that package. A single M+C contract would be awarded to the lowest bidder in each county. This approach might prove helpful if the health plans' main concern is that they will be followed by other plans into sparsely populated rural counties. If their main concern is low payment levels and the difficulty of organizing provider networks, and if the bidding takes place under rules limiting payments to budget neutral levels, then the one-winner" proposal will have little effect on their willingness to enter rural counties.

Another potential setting for the one-winner strategy would be an area with more than one competing health care system in place. A rural area served by more than one hospital within a reasonable driving distance could be a candidate. The one-winner approach would allow the winning bidder to amass enough enrollees to realize some economies of scale (although the winner still must compete against FFS Medicare). Providers who contracted with the losing bidder still would be able to see patients under the traditional FFS Medicare payment system. An important concern is whether the losing bidder would be able to survive for a period of time without a M+C contract and be a viable participant at the next round of bidding.

Geographic capitation under FFS Medicare

At a conference sponsored by the National Institute for Health Policy in September 1999, John Wennberg introduced a geographic capitation model to encourage the use of effective medical treatment by FFS Medicare providers. This proposal is still in the formative stages. The basic idea of geographic capitation is to allow health care providers in a geographic area to negotiate a global capitation rate for the care of all Medicare beneficiaries in the area. Although this proposal gives the physician community at large an incentive to consider the medical effectiveness of the treatments they recommend, it contains no element of competition, since it involves all the providers in the area. ³⁰ If only a subset of providers were included in the capitation program, then the only difference between that subset of capitated providers and current M+C plans would be the use of *negotiated* capitation rates, rather than capitation rates computed by HCFA.

The geographic capitation approach may be worth considering in rural areas that lack sufficient resources to support more competitive alternatives – i. e., for certain kinds of rural areas where resources are too thin to imagine a multi-plan bidding process.

³⁰ It differs in that way from the "private FFS plans" which were instituted under the 1997 BBA legislation.

Rural areas that are contiguous to urban areas

One approach to a rural demonstration is to choose rural counties that are adjacent to MSAs. In fact, most of the rural M+C service area reductions from 1999 to 2000 took place in counties that are contiguous to higher payment urban counties (data from Medicare Compare – not shown).

The most important demonstration design issues to consider in such counties would be:

- 1. the rules governing M+C participation in the contiguous rural counties and
- 2. the way that payments are set.

CPAC considered both of these issues in its deliberations over the design of the Competitive Pricing Demonstration.

a) Rules regarding M+C participation in counties

There are two alternatives for M+C plan participation rules within a demonstration site that includes both an MSA and surrounding rural counties. The first is to let plans designate the counties they will serve. That policy is the status quo. Currently, a plan can choose to serve only four of seven counties in an MSA, and none of the contiguous rural counties, for example, or a plan might choose to serve all of the MSA counties and one contiguous rural county. The advantage of allowing plans to define their own service areas is that plans have better information than the government about their ability to serve specific areas. It may be inadvisable and possibly dangerous to require plans to serve beneficiaries in areas that they would not otherwise choose to serve. The *disadvantages* of allowing plan discretion are two-fold:

- 1) under the current administrative pricing system, plans make strategic decisions about which areas to serve and which to avoid, based on the somewhat arbitrary payment levels in each county, and
- 2) the information contained in their strategic decisions is never fed back into the payment-setting process to achieve some desired objective.

The second approach to plan participation is to impose some type of constraint on health plan participation, e.g., require plans who wish to serve a desirable urban area to include some rural counties in their service areas, as well. The advantage of this approach is that M+C plan participation in some areas may increase. The primary disadvantage is that plans may be forced to serve areas that they are poorly equipped to serve.³¹ After careful

January 19, 2001 Page 65

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³¹ A variation of this approach is to apply the constraint to different types of enrollees, rather than different geographic areas. In other words, M+C plans might be told that if they want to offer their services to federal government employees in a county, they also must offer an M+C plan to Medicare beneficiaries. There are several reasons to be concerned about this proposal. First, plans that are able to serve the commercially insured population well may not be as well equipped to deal with the needs of the elderly and disabled

consideration of these issues, CPAC decided to allow M+C plans to designate their own service areas within the Demonstration site, i.e., to serve some counties and not others.

b) Rules regarding payments in different demonstration counties

Turning to the issue of payment policy, CPAC considered three alternative approaches to payments among the different counties in demonstration areas. These alternatives were developed in the context of an urban demonstration, but CPAC's logic in considering them applies to an urban demonstration site that includes contiguous rural counties, as well.

The first approach was to have plans submit one bid for the entire demonstration area. This approach was considered unworkable in light of CPAC's decision to allow plans to designate their own service areas within the Demonstration site. If M+C plans are allowed to submit only one bid for all the counties they serve, plans will have a perverse incentive to serve only low-cost counties.

The second approach was to allow plans to submit different bids for each county. Although this approach allows the maximum flexibility and tailors competitive prices to market conditions in each county, it is administratively complex and can result in beneficiaries in adjacent counties paying different out-of-pocket premiums for the same health plan. That outcome might not be objectionable in a more developed competitive pricing system, but CPAC believed it would be disruptive in an initial demonstration.

The third approach was to have plans bid on a standardized enrollee (i.e., a beneficiary with a specific set of demographic and health risk characteristics) in a baseline county in the demonstration area (e.g., Jackson County in the Kansas City demonstration area). This standardization of the bids ensured that the bids were comparable. Payment rates for other types of enrollees, or enrollees in other counties, was calculated by multiplying the standardized bids times the ratio of payments in other demographic and risk categories and other counties, to payment for the standardized enrollee in the baseline county. The *ratios* were derived from current payment levels, and to that extent incorporated the limitations of current payments. But the AACs concluded, on balance, that this simplified approach would be more practical to administer.

population. Second, proposals of this type appear to be based on the theory that one set of enrollees is more profitable than another – in this hypothetical case, that federal employees are more profitable than Medicare beneficiaries. If that were the case, it would suggest that something was structurally wrong in the payment system for federal employees that allowed the existence of abnormally high profit levels in the long-run. The proper solution would to correct the payment system for federal employees, rather than using the flaws in that system to entice M+C plans to serve counties they would not choose to serve, otherwise.

³² M+C plans currently can offer different benefits and premiums in different counties, but they must open a new health plan (with a different plan identifier) to do so.

However, the third approach might not address the problem of encouraging M+C plans to enter rural areas. County-to-county payment ratios based on current payment levels would not increase the level of payments to contiguous rural counties unless the bid for the baseline county exceeded the current payment level for the baseline county. Thus, if CPAC is to consider a demonstration involving rural counties that are contiguous to MSAs, it may be necessary to allow plans to submit separate bids for the rural counties and to develop a separate government premium contribution for those rural counties, despite the administrative complexity of that approach and the likelihood that the median or enrollment-weighted average bid will exceed the current (budget-neutral) payment level.

State partnerships

One of the difficulties faced by rural areas is the lack of economies of scale in the administration of various public insurance programs. One way to overcome that problem might be for state governments to take the M+C payment rate for beneficiaries in a subset of rural counties in the state, and to allocate those dollars across counties in conjunction with other public insurance programs, particularly Medicaid. In some areas, local governments actually have started their own health plans (i.e., Hillsborough County, Florida) and in other cases county governments have accepted capitation payment rates from the state and provided a mix of private and public care system alternatives to Medicaid beneficiaries (i.e., Minnesota). Coordination of programs for the elderly, disabled, Medicare, Medicaid and dually-eligible populations might result in both reduced administrative costs and increased efficiency in the delivery of services, as well.

4.4. Summary

CPAC realized that health care in rural areas faces many challenges, and not all of those challenges can be met by government policy. However, CPAC remains interested in exploring the possibility that the two primary policy "levers" at its disposal – the level and structure of payment to M+C plans and FFS providers – could lead to improvements in the health care delivery system in rural areas.

CPAC concluded that it was a mistake to force M+C plans to serve counties they currently are not well equipped to serve. CPAC also realized that if M+C plans were willing and able to serve specific counties at current payment levels they already would be doing so. If it is deemed desirable to encourage M+C plans to expand their service areas, it will be necessary to determine the payment level that is adequate to support that expansion. One approach, the status quo, is to allow payments levels in low-payment counties to increase (in the manner provided through global administrative formulae of current policy under the BBA and the BBA Refinement Act) until plans are coaxed into serving those counties. Another, quicker, method would be to have plans submit bids that reflect their estimated costs *now* of adequately serving a target rural county. Those bids would have to be disciplined by some process. Giving a "one-winner" contract to the lowest-priced qualified M+C plan would be one option. Another option is to allow multiple winners and use the

same incentive as CPAC's "urban" model (i.e., higher out-of-pocket premiums) to discipline bids in rural counties.

It is unlikely that the "one-winner" approach alone, will lead to a successful demonstration of competitive pricing in a rural county. M+C plans face too many additional obstacles in rural counties for the incentive here – sole provider status in a rural county – to elicit substantial changes. In order to justify the level of private investment necessary to develop provider contracts and offer a benefit package that competes successfully with FFS Medicare, it is likely that payment levels in a rural demonstration site will have to increase beyond those specified in the 1997 BBA legislation. Those increases will require a waiver of the budget neutrality constraint.

CPAC therefore concludes that, in order to proceed with a rural demonstration project, CPAC must have the flexibility to experiment with a number of different demonstration designs. It may be necessary to develop enabling legislation that:

- 1. Allows the award of a single M+C contract for some counties, and
- 2. Waives the existing budget neutrality constraint, perhaps with:
 - a). some specified maximum expenditure on rural demonstration sites
 - b). an expansion of the budget neutrality calculation, to apply over the entire demonstration period and/or across all sites.

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Appendix

Background data on rural U.S. counties

It is difficult to appreciate the special difficulties of a rural demonstration of competitive pricing without some understanding of the characteristics of rural areas in the U.S. To that end, this appendix compares rural and urban areas in the U.S. on a variety of measures, including general demographics and managed care participation in Medicare, Medicaid and commercial insurance markets.

There are 852 urban counties in the U.S. (as of March 2000) and 2,280 rural counties. The data show that urban and rural areas differ in important ways. The availability of health care providers and facilities is greater in urban areas. Income is higher in urban areas, and the proportion of the elderly living in poverty is lower.

Despite a lower presence of managed care in rural areas, 62 rural counties in the U.S. were served by two or more Medicare+Choice (M+C) plans in December 1999. States with particularly high M+C market penetration in rural areas include Massachusetts, Pennsylvania, Hawaii, Arizona, and Washington. Among M+C plan enrollees, 33.6 percent of rural enrollees are in zero premium plans, compared to 63.2 percent of urban enrollees. The average monthly premium is \$23.87 in rural areas, compared to \$23.31 in urban areas. Further analysis (not shown in these tables) shows that the M+C payment rate in some of the rural counties with two or more M+C plans is sufficient to support an outpatient prescription drug benefit in a zero premium plan.

States with <u>Medicaid</u> managed care market penetration rates exceeding 20 percent include Arizona, Delaware, Hawaii, Kansas, Kentucky, Maryland, Michigan, New Mexico, Oregon, Tennessee, Vermont, Washington, and Wisconsin. <u>Commercial</u> managed care enrollment by county is available in only a few states, and not consistently over the years 1995 to 1999. Among the few states reporting these data, California, Missouri, New York, and Pennsylvania and Wisconsin have relatively high managed care penetration rates among commercial enrollees.

These data suggest two things:

1. In terms of number of plans available, current payment rates, and current benefit levels, a rural demonstration might be feasible in at least a few counties. However, counties in which the demonstration might be conducted are by no means typical rural counties facing the problems of low M+C plan participation, inadequate access to health care services and low benefit levels that are the primary concerns in rural areas. Thus, even if a rural demonstration was conducted successfully in one of these atypical rural counties, it is not clear what lessons could be generalized to the vast majority of rural U.S. counties.

2. Competition even in those atypical counties is fragile, at best, and if the purpose of the demonstration primarily were to demonstrate competitive pricing, per se, those counties would be a poor choice for a demonstration.

I. Introduction and general market area characteristics

We begin with general data comparing urban and rural counties on a number of dimensions. As noted in Chapter 4, we have defined an "urban" county as a county within a metropolitan statistical area (MSA). A "rural" county is a county not included in any MSA. Table A1 shows data from the Area Resource File (ARF) for rural and urban counties in the U.S..

Table A1: Characteristics of Urban and Rural Counties

	Rur	al	Urban		
Characteristic	Mean	Std Dev	Mean	Std Dev	
Total General &Family Practice MDs, 1997	6	9	61	119	
Total US Graduate MDs, 1997	29	136	606	1,442	
Total Hospitals, 1996	1	1	589	9	
Total Admissions, 1996	2,588	8,650	34,525	76,605	
Total Beds, 1996	104	277	1,046	2,282	
HMO membership, 1997	717	17,958	91,486	417,591	
Number IPA HMOs, 1997	0	0	0.4	1	
Number of IPA Member, 1997	369	9,597	34,256	120,793	
Inpatient days in short stay hospitals, 1996	18,285	53,914	198,723	456,082	
Total Enrollment, Part A &/or Part B, 1991	3,736	4,424	32,012	64,483	
Estimated Population, 1997	24,187	29,952	267,817	586,261	
Male, age 65-74, 1990	846	986	7,538	15,589	
Female, age 65-74, 1990	1,047	1,301	9,748	20,439	
Male, age 75-84, 1990	437	472	3,473	7,302	
Female, age 75-84, 1990	688	823	5,912	12,362	
Male, over age 85, 1990	103	106	783	1,710	
Female, over age 85, 1990	247	289	2,080	4,383	
Per Capita Income, 1996	\$17,845	\$3,427	\$22,558	\$5,306	
Number Persons 65+ below poverty, 1989	578	654	3,076	6,310	
% of Elderly below poverty, 1989	17%	38%	10%	30%	

Source: Area Resource File

II. Medicare managed care data

The next set of tables compares information about Medicare+Choice (M+C) plans in rural and urban areas. Matching M+C plans to counties presents some interesting problems. The first problem is that, in many cases, M+C enrollees live in counties that are not within the service areas of those plans. A second problem is that an M+C plan might list a county within its service area, but have no enrollees in that county. To address these problems, we present two sets of results for some of the data. In the first set of results, counties and plans are "counted" if the M+C plan lists the county within its service area (whether it has any enrollees in that county or not). In the second set of results, plans and counties are "counted" only if the M+C plan has some enrollees in the county. The lower cutoff for the

number of enrollees is 11 because HCFA no longer reports the number of enrollees for counties with ten or fewer enrollees due to privacy concerns. In some cases, the different definitions make a significant difference.

Tables A2 and A3 display some initial results. Table A2 suggests that 12 percent of all rural counties are within the designated service area of at least one M+C plan, but only 3 percent have 2 or more plans. States with high rural M+C market penetration include Massachusetts, Pennsylvania, Hawaii and Arizona. Zero premium plans are much more prevalent in urban areas, and the average premiums charged by M+C plans are lower in urban areas.

Table A2: Number Of Counties That Are Listed Within M+C Plans'
Services Areas (Based on March 2000 data. Some of the M+C plans may have 10 or fewer enrollees in some of these counties)

	Rura	al	Urb	an
Number of M+C Plans in County	Number of Counties	% of total	Number of Counties	% of total
0	2,005	87.9%	336	39.4%
1	204	9.0%	159	18.7%
2	54	2.4%	111	13.0%
3	12	.53%	81	9.5%
4	4	0.2%	84	9.9%
5	0	0.0%	24	2.8%
6	1	0.0%	26	3.1%
7	0	0.0%	14	1.6%
8	0	0.0%	7	0.8%
9	0	0.0%	2	0.2%
10	0	0.0%	6	0.7%
11	0	0.0%	1	0.1%
12	0	0.0%	1	0.1%
Total	2,280	100.0%	852	100.0%

Total percentages do not exactly equal sums of the columns due to rounding.

Source: Medicare Compare

(I.e., there are 54 rural counties that are within the service areas of 2 M+C plans, although some of the plans may not have any enrollees in those counties.)

Table A3: Number of Counties That Are Listed Within M+C Plans' Services
Areas (Based on March 2000 data. Each plan has at least 11 beneficiaries in the county)

	Rura	al	U	rban
Number of M+C Plans in County	Number of Counties	% of total	Number of Counties	% of total
0	2,032	89.1%	339	39.8%
1	186	8.2%	161	18.9%
2	46	2.0%	112	13.2%
3	12	0.5%	79	9.3%
4	3	0.1%	84	9.9%
5	0	0.0%	24	2.8%
6	1	0.0%	22	2.6%
7	0	0.0%	16	1.9%
8	0	0.0%	6	0.7%
9	0	0.0%	2	0.2%
10	0	0.0%	5	0.6%
11	0	0.0%	1	0.1%
12	0	0.0%	1	0.1%
Total	2,280	100.0%	852	100.0%

Total percentages do not exactly equal sum of the column due to rounding.

Source: Medicare Compare

(I.e., there are 46 rural counties that are within the service areas of 2 M+C plans, counting only those plans that have at least 11 enrollees in those counties.)

Table A4: Average Number Of M+C Plans In A County (March 2000)

Plans Included	Rural	Urban
All M+C Plans	0.16	1.75
M+C Plans with at Least 11 Beneficiaries	0.15	1.71

Source: Medicare Compare

(I.e., among all rural counties, the average number of M+C plans with at least 11 beneficiaries is 0.15.)

Table A5: Market Penetration Rates of Medicare Managed Care (March 2000)

	ie A5. Warke	Rural	<u> </u>	Urban	
		Rului	Percent	Number of	Percent
	State	Number of Enrollees	Penetration	Enrollees	Penetration
1	AK	- 0.007	-	- 50.470	-
2	AL	3,007	1.2%	52,173	11%
3	AR	4,282	1.6%	11,708	6.4%
4	AZ	9,421	9.7%	234,899	39.8%
5	CA	1,811	1.0%	1,468,281	38.6%
6	CO	2,655	3.0%	134,411	34.7%
7	CT	-		96,010	18.9%
8	DE		-	3,590	4.4%
9	FL CA	5,337	2.3%	728,598	27.7%
10	GA		44.00/	45,849	8.1%
11	HI	5,022	11.0%	14,687	12.0%
12	IA ID	-		2,184	1.2%
13	ID	-	0.40/	5,115	9.0%
14	L	521	0.1%	140,159	10.6%
15	IN	45	0.0%	11,903	2.0%
16	KS	_		24,924	13.0%
17	KY	- 0.544		24,950	8.9%
18	LA	9,511	5.7%	80,203	17.8%
19	MA	2,578	17.0%	229,269	23.8%
20	MD	- 450	- 0.40/	69,452	11.7%
21	ME	150	0.1%	1,391	1.2%
22	MI	330	0.1%	46,314	4.1%
23	MN	86	0.0%	47,271	11.8%
24	MO	1,567	0.5%	125,052	22.8%
25	MS	_	_	287	0.2%
26	MT	7.500	4.70/	27.400	F 20/
27 28	NC ND	7,532	1.7%	37,496	5.3%
29	NE NE	_		8,098	7.6%
30	NH	_		1,526	1.3%
31	NJ	_	<u>_</u>	161,352	13.2%
32	NM	2,343	2.1%	41,985	32.4%
33	NV	14	0.0%	37,431	18.0%
34	NY	6,498	2.7%	425,711	16.9%
35	OH	7,940	2.4%	261,639	18.7%
36	OK	4,051	1.7%	46,440	16.9%
37	OR	8,443	5.0%	130,731	39.8%
38	PA	54,109	15.4%	503,072	28.3%
39	RI	-	- 13.170	57,530	33.1%
40	SC	_			-
41	SD	12	0.0%	219	0.6%
42	TN	4,661	1.4%	37,787	7.2%
43	TX	15,111	2.9%	315,273	17.7%
44	UT		-	=	=
45	VA	725	0.3%	24,282	3.9%
46	VT	-		- 1,202	
47	WA	13,170	7.9%	147,476	25.4%
48	WI	1,361	0.4%	30,603	6.1%
49	WV	32	0.0%	3,813	2.7%
50	WY	=	-	-	-

[&]quot;-" symbol means no rural HMOs designated within service areas.

Source: Medicare Compare

Table A6:Average Market Share Of Individual M+C Plans (March 2000, based on total M+C enrollment in counties with at least one M+C plan – excludes FFS enrollment)

Rural Urban
67 percent 34 percent
Source: Medicare Compare

(I.e., in rural counties that are within the service area of at least one M+C plan, the average market share of all plans is 67 percent. For increased competition, this number should be lower. The rural figure is higher than the urban figure, because in rural areas there is more likely to be only one M+C plan.)

Table A7: Average Number Of Zero Premium M+C Plans (March 2000; includes only counties that are within at least one M+C plan's service area)

Counties within the service area of:	Rural	Urban
Any M+C Plan	0.53	1.46
M+C Plan that has 11 or more enrollees in the county	0.50	1.42

Source: Medicare Compare

(I.e., in all rural counties that are within the service area of at least one M+C plan, the average number of zero premium plans is 0.53. That average includes plans with no enrollees.)

Table A8: Proportion Of All M+C Enrollees That Are In Zero Premium Plans (March 2000, based on plans that have at least 11 enrollees)

Rural	Urban
33.6 percent	63.2 percent
Source: Medicare Compare	ı

(I.e., among all rural counties that are within the service area of at least one M+C plan, the average proportion of M+C enrollees in zero premium plans that have at least 11 enrollees in that county is 33.6 percent.)

Table A9: Enrollment-Weighted Average Premium (March 2000, based on plans that have at least 11 enrollees)

Rural	Urban	
\$ 23.87	\$ 23.31	
Source: Medicare Compare	I `	

(I.e., the enrollment-weighted average premium charged by health plans in all rural counties, including zero premium plans, is \$23.31.)

III. Medicaid managed care data

There was an overall increase in rural Medicaid managed care market penetration rates between 1996 and 1998-99, but the increases vary by state. There were 12 states in 1998-99 with zero rural Medicaid managed care enrollees.

Table A10: Rural Versus Urban Medicaid Managed Care
Market Penetration Rates By State 1998-99

	Market Penetrat	tion Rates By State 1998-99
State	Rural	Urban
1 A	\L	0.0% 12.4%
2 A	AR .	0.0%
3 A		0.0% 100.0%
4 C	Ä	0.0% 35.4%
5 C	XO .	9.8% 31.1%
6 C	т	- 74.4%
7 D	OC	- 0.0%
8 D	DE 7	6.5% 79.0%
9 F	L 1.	2.1% 31.9%
		1.5%
11 H	11 8	1.1% 75.8%
12 K		2.6% 31.5%
13 II		0.0%
14 L	_	0.1% 27.3%
15 II		1.2% 26.8%
		7.6% 87.3%
		2.9% 59.5%
		0.0%
		0.7% 15.8%
		4.2% 67.9%
		2.5% 11.3%
		4.4% 72.5%
		8.2% 62.4%
		1.3% 56.7%
		2.6% 6.2%
		0.0% 9.8%
		0.0% 4.5%
		0.0% 5.2%
		0.0% 33.6%
		2.1% 15.8%
	JJ	- 56.7%
		4.5% 78.8%
		0.0% 26.6%
		2.8% 29.6%
-		0.0% 22.0%
		2.2% 77.4%
		4.8% 81.3%
		3.7% 62.9%
39 R		- 65.1%
		0.7% 2.5%
		0.0%
		0.0% 100.0%
		4.6% 26.0%
		0.5% 80.2%
		0.1% 29.0%
		9.3% 59.9%
		1.8% 60.2%
	***	4.7% 51.8%
		9.3% 35.4%
		0.0%
		District of Columbia did not report data Alaska

Notes: " - " = no rural areas in the state. The District of Columbia did not report data. Alaska reported no HMOs

Source: Rural Health Research Center, University of Minnesota

(I.e., the Medicaid managed care market penetration rate in rural Colorado is 9.8 percent.)

IV. Commercial managed care data

Table A11 below compares urban and rural <u>commercial</u> managed care market penetration rates for states that report commercial HMO enrollment by county. These data were provided by the Rural Health Care Research Center, Division of Health Services Research and Policy at the University of Minnesota. They are still undergoing final checks and should be considered preliminary estimates at this time.

A. Commercial enrollment

The number of states reporting county-level data on commercial HMO enrollment has increased, from eight in 1995 to in fourteen in 1998 and 1998-99.³³ The results are as follows:

- The overall rural and urban commercial enrollment rates for the states with data have increased from 7.8% to 14.1% (rural) and 25.7% to 36.4% (urban) from 1995 to 1998-99.
- In all states with county-level data, commercial enrollment in rural areas increased between 1995 and 1998-99. Wisconsin and Pennsylvania continue to have the highest rural commercial enrollment rates, with one-fourth of their rural populations enrolled in HMOs as of 1998-99. New York at 23.2% is next, followed by California (15.7%) and Missouri (14.9%). North Dakota, Wyoming, and Montana, three very rural states, have very low rural commercial enrollment rates (less than 3%). Massachusetts, a predominantly urban state, also has a low rate in its rural counties.

³³ 1998 and 1999 are treated as one year, although data are presented separately for the two years in Table A11. Some data for 1999 still are being collected. Some data for 1998 are from December 1998. The discussion below refers to the most recent data available over the 1998-99 period.

	Č	County (Pre	eliminary [Data, Janua	ary 2000)			J .		,
	199)5 a)	199	6 b)	199	7 c)	199	8 d)	1999	9 e)
State	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural
CA	-	-	-	-	42.7%	14.9%	45.6%	15.7%	46.4%	16.6%
FL	24.3%	4.9%	28.7%	6.0%	30.0%	7.8%	32.0%	9.3%		
MA	-	-	-	-	40.9%	1.6%	40.9%	2.6%		
MN	35.8%	5.5%	31.4%	7.3%	30.7%	9.8%	26.8%	8.9%		
МО	26.2%	6.3%	27.9%	10.5%	30.6%	14.7%	30.1%	14.9%		
MT									6.8%	1.2%
NJ							23.8%	No rural		
NY	-	-	30.2%	20.8%	32.8%	20.2%	36.0%	23.2%		
NC	13.6%	4.2%	17.9%	7.2%	20.9%	8.8%	22.1%	9.4%		
ND	-	-	-	-	-	-	6.1%	2.3%		
OK	-	-	16.0%	2.7%	17.6%	3.6%	-	-		
PA	30.8%	12.0%	36.1%	18.6%	39.1%	23.5%	39.4%	25.3%		
SC	9.7%	4.6%	-	-	14.3%	8.2%	14.8%	8.7%	15.3%	8.6%
WV	-	-	-	-	12.5%	5.1%	13.3%	5.4%		
WI	35.7%	17.0%	36.9%	20.9%	37.4%	24.4%	39.1%	25.4%		
WY	0.0%	6.0%	-	-	-	-	3.2%	2.6%		

TABLE A11: Commercial HMO Market Penetration Data From States Reporting Enrollment Data By County (Preliminary Data, January 2000)

All denominators based on census estimates of population < 65, including Medicaid eligibles.

- a) Wisconsin data as of January 1, 1996. Wyoming data as of November 1, 1995. All other states as of December 31, 1995.
- b) New York data as of March 31, 1996. Wisconsin data as of January 1, 1997. Oklahoma data are estimates based on subtracting Medicaid and Medicare from total enrollment; dates throughout 1996 are based on license renewal dates of individual HMOs. All other states as of December 31, 1996.
- c) California data as of March 1997, New York data as of March 31, 1997, and Wisconsin data as of January 1, 1998. All other states December 31, 1997.
- d) California data as of March 1998. New Jersey and South Carolina data as of September 30, 1998. Florida, Massachusetts, North Carolina, and Wyoming data as of December 31, 1998. Wisconsin data as of January 1, 1999. North Dakota data is from individual HMOs, and dates range from June 30, 1998 to January 1999.
- e) California and South Carolina data as of March 1999. Montana data is from individual HMOs as of June 1999.

Source: Interstudy and the Rural Health Research Center, University of Minnesota

B. Relationship between presence in an HMO service area and commercial enrollment in counties with commercial data

Fourteen states had commercial HMO enrollment data by county in 1998-99. Within these 14 states, the majority of rural counties were in the service area of at least one commercial HMO, and nearly all rural counties had some commercial HMO enrollees. However, a significant proportion of the rural counties in these 14 states had very low HMO penetration rates. Of the 538 rural counties in these states with commercial enrollment data in 1998, only 221 had managed care penetration rates of more than 10 percent.

Table A12. Managed Care Market Penetration	n In Rural Areas (1998, for the 14 states reporting
commercial HMO enrollment data)	

Market penetration	Number of counties
0 – 3 percent	148
3.1 to 9.9 percent	177
10 percent or more	221

For all rural counties in the 14 states with commercial enrollment data in 1998-99, the correlation between the number of HMOs serving the county and the enrollment rate is not very high (0.31 in 1995, 0.33 in 1996, 0.25 in 1997). There is considerable variation by state, e.g., in 1997, 0.06 in SC and 0.71 in NC.

C. Relationship between commercial and Medicaid managed care enrollment in counties with commercial data

In the 14 states reporting commercial enrollment by county, the majority of rural counties have commercial enrollees. These states may not be typical, however, since most of the states reporting commercial enrollments by county have relatively high rural rates of commercial enrollment.

- 1. Six states have no Medicaid managed care enrollees. In 1998-99, 391 (66%) counties in these 14 states have commercial but no Medicaid enrollment; 156 (26%) have both commercial and Medicaid enrollment, and 44 (7.4%) have neither. However, Medicaid managed care enrollment in the absence of commercial enrollment is almost non-existent (0 counties in 1995 and 1996, 1 county in 1997 and 1998-99).
- 2. Only 3 states have rural Medicaid managed care rates that exceed their rural commercial rates (MN, FL, WI). In some cases, this may be due to the fact that the Medicaid population in many counties is served by Medicaid-only plans (i.e., Tennessee). In those states, Medicaid enrollment may exist in rural counties where commercial enrollment does not.

Chapter 5.

The Benefit Structure

5.0 Introduction

For plans to submit competing bids and for the government to evaluate those bids in a competitive process, there must be agreement on what the bids actually buy. That requires some understanding of the benefit package that plans offer as part of their bids. The benefit package also plays a critical role in determining the financial protection and exposure of beneficiaries. The specification of the benefit package was, accordingly, one of the most important issues addressed by the CPAC as it set out to design the Competitive Pricing Demonstration.

The CPAC took a careful approach to benefit design. The committee defined certain parameters of the benefit package (e.g., requiring all plans to bid on a standard benefit package that was equivalent to the greater of a national minimum and the local market norm), but gave the local AACs discretion to specify the details of the benefit package in view of local preferences and concerns.

Congress has asked the CPAC to review issues surrounding the specification of the benefit package. Specifically, Congress has asked the committee to report on the following issues concerning the "benefit structure": ³⁴

- 1. The nature and extent of the benefit structure that should be required of plans participating in the project [and] the rationale for such benefit structure,
- The potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project,
- 3. The potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and
- 4. The potential implications of expanding the project (in conjunction with the potential inclusion of the original Medicare fee-for-service program) to require Medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

The fourth issue above can be discussed more conveniently in conjunction with the questions of including fee-for-service Medicare in the demonstration (see Chapter 2 above). The first three issues are the subject of this chapter. We begin by laying out the details of the benefit structure that the CPAC required and then proceed to discuss the rationale for

³⁴ The four issues set forth in the text above follow the wording of Section 533 of the BBA Refinement Act of 1999.

that structure and the advantages and disadvantages of alternatives. This extended discussion includes explicit consideration of the issues Congress has raised concerning standardization, allowing reductions in some standard benefits (e.g., a higher percentage of out-of-pocket costs) in exchange for a lower premium, and allowing premium rebates.

5.1 CPAC and AAC decisions about the benefit package

The essential features of the benefit package as determined by the CPAC and the Kansas City and Phoenix AACs were as follows. 35

- Standard benefit on which all plans bid CPAC recommended that all plans submit bids on a common or "standard" benefit package. This package could be thought of as a substitute for the basic benefit packages currently being offered in the demonstration sites.
- Minimum national benefit The demonstration's standard benefit package was to be based on a national minimum standard package composed of the statutory Medicare benefit plus a limited outpatient prescription drug benefit (covering a minimum of \$500 of expenditures with cost sharing).
- Benefit enhancements permitted up to the approximate norm for the market area Benefit enhancements beyond the national minimum were permitted to the extent of the market norm in each demonstration site. Thus, prescription drug benefits could be expanded beyond \$500 to the area norm, and other benefits included in the area norm could be added to the statutory benefit.
- Area Advisory Committees (AACs) to determine the details of the benefit in each demonstration site The specification of standard benefit packages requires decisions on numerous details, and those details are important. For example, in setting the prescription drug benefit alone, a whole array of subsidiary issues must be resolved, such as: How will plan formularies be treated? Will copayments be the same for multiple- and single-source drugs? Which prices (e.g., acquisition cost, average wholesale price, or other) are applied against the expenditure cap? What prices are beneficiaries required to pay (e.g., retail pharmacy or plan acquisition prices) after the cap is reached? CPAC believed that decisions of this sort could best be made by the AACs. The AACs know the current methods and capabilities of health care delivery in local areas. The AACs could investigate local conditions as needed and bring local preferences to bear on the tradeoffs among benefits.
- Low bidders permitted to enhance their standard benefit packages offered at
 zero premium or to offer premium rebates Plans that bid below the

January 19, 2001 Page 82

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³⁵ These design decisions are reflected in the CPAC Design Report (Competitive Pricing Advisory Committee, "Design Report of the Competitive Pricing Advisory Committee," January 6, 1999); and, with respect to premium rebates, in the minutes of the CPAC meeting, October 29,1999.

government contribution to premiums (as determined from the plans' bids) were to be paid the amount of the government contribution, not the amount of their bids. Low-bidding plans were given a number of options as to what they could do with the difference between their bids and the government contribution: they could enhance their standard benefit packages (thus offering an enhanced standard package at zero premium to beneficiaries), offer a premium rebate (up to the amount of the Part B premium), retain the difference, or adopt some equivalent combination of the three options. These options give lower bidding plans the opportunity to offer additional benefits attractive to beneficiaries and to create market advantages. Premium rebates were added to the demonstration design in the fall 1999 to help offset concerns about the disruptive effects of the demonstration. ³⁶

- Plans can offer as many supplementary benefits as they choose at the price they choose Plans were permitted to offer supplementary benefits as additions to the standard benefit package at full cost to beneficiaries. There was to be no restriction on the number or type of such benefits, or the premiums that M+C plans could charge for them, apart from the requirement that these benefits be offered as additions to the standard benefit.
- <u>Plans allowed to adjust benefits mid-cycle</u> Six months after the effective enrollment date associated with an open-enrollment period, plans were allowed to enhance, but not reduce, their supplementary or standard benefits.
- No formal coordination with Medigap plans CPAC decided that Medigap plans should not be required to coordinate their benefit packages or other terms with the terms of the demonstration. However, the committee emphasized that beneficiaries should be given information about Medigap plans, as part of the special efforts made to inform beneficiaries about their options under any competitive pricing demonstration.

The following sections discuss the rationale for these provisions, and address the issues Congress has raised.

January 19, 2001 Page 83

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³⁶ As noted in Chapter 1, CPAC had set aside the premium rebate option in early design discussions, following briefings by HCFA on the substantial administrative difficulties of including premium rebates and possible legal difficulties as well (e.g., with the anti-kickback statutes). By late 1999, however, the demonstration had run into substantial local opposition, and CPAC and the AACs were exploring ways to make the demonstration design more attractive to beneficiaries. The Clinton Administration had made public a proposal for Medicare reform that, among other things, included a provision for premium rebates. Congress made clear that premium rebates were consistent with demonstration authority (a position soon made explicit in Section 533 of the BBA Refinement Act). At that point, CPAC decided to revisit the rebate issue and approved the addition of premium rebates to the demonstration design.

5.2 Requiring a standard benefit package of all plans

One of the most important choices in defining the benefit package is the question of standardization: should all health plans be required to bid on the same package of benefits? There are arguments on both sides of this question. But the CPAC concluded that a standardized package was essential.

In the abstract, health plans could be allowed to submit bids for any package of benefits of their own design that meets statutory requirements or some other standard set for the bidding (for discussion of the level of benefits, see Section 5.5 below). Doing away with standard benefits has three advantages:

- It might increase the diversity of products in the market
- It would give plans more discretion.
- It might correct discrepancies between the market and an administratively determined standard benefit package.

In a sense, the first advantage follows from the other two. Consider the second point – that dropping standard benefits would give plans more discretion. Some of this discretion concerns ordinary administration and operations. If the plan gets to specify the benefit package, it can be sure that the specified benefits mesh with financial systems, provider agreements, and other arrangements. Standardization would require changes in such areas, and those changes take time and resources. But some of the discretion concerns basic operational philosophies. Particular plans may be especially good at offering benefits that are not part of a standard package. By allowing those plans to choose what they want to offer, the diversity of products in the market is increased. Finally, to the extent the standard benefit does not reflect the market, dropping the standard benefit requirement would provide plans the latitude to correct any discrepancies.

Absent other considerations, these ordinary notions of producer and consumer sovereignty would decide the question. But there are other, profound considerations against allowing bidding on just any benefit and in favor of requiring bids on a standard benefit, at least for a common core of benefits. On balance, CPAC found these other considerations compelling. First, a standard benefit is required to enhance competition. This requirement has two important aspects:

Simplifies comparison of bids – When the government receives bids, it has to be able to compare them in some practical way that meets the standards of rigor and fairness required of a government procurement. A clean comparison of bids by the government is essential because the federal government must maintain procedural and substantive fairness when it procures goods and

services. Experts from public and private health benefit programs who addressed the CPAC urged the CPAC to adopt a standard benefit.³⁷

Simplifies beneficiary education – It is difficult to educate consumers to understand their options and make informed choices. A standard benefit package (for at least a basic package of benefits) facilitates comparisons by beneficiaries as well as the government and allows the government to provide relatively simple comparative information to highlight the differences among plans. Without some standardization of the benefit package, plans might cut benefits in ways that beneficiaries could not detect prior to enrollment, but that might harm beneficiaries once they became ill.

Thus, a standard benefit would tend to enhance competition. It would also tend to make the demonstration more operationally practical. If the Competitive Pricing Demonstration was to be a prototype for possible national implementation, it must be based on a model that can be practically implemented across the country. Allowing non-standard bids would make the evaluation process extremely labor intensive and difficult to generalize beyond a few demonstration sites that would receive special attention and resources.

At the same time, a standard benefit package reduces the opportunity for plans to use benefit variations to manipulate risk selection. The abstract ideal of consumer sovereignty fails to take account of the ways that, in a health care market, benefits can be manipulated to "skim" the market and otherwise to distort costs among producers. A member of the CPAC panel offered an example of benefit manipulation – if the Federal Employees Health Benefits Plan let plans select their own benefits, dental coverage would be added and blood transfusions would be dropped. In other words, the plans might add a highly-visible benefit that is attractive to healthy workers and drop a less-visible benefit that is needed by those who are sick. CPAC felt that the Competitive Pricing Demonstration should be seeking ways to pay plans fairly for managing risks, not avoiding them, and (particularly in the absence of perfect risk adjustment of payments or any practical way to deter this behavior by administrative oversight) a standard benefit was important, practical reassurance against risk selection.

The issue of benefit standardization needs to be kept in perspective. There are many characteristics of plans such as the size of their provider networks, access to specialists inside and outside their networks, clinic locations, and other factors that are not affected by standardization. In other words, benefit standardization affects only the insurance aspect of M+C plans, not their delivery systems, per se.

³⁷ These experts included the former Deputy Director of the Arizona Health Care Cost Containment System (AHCCCS); the Director of Managed Care Plans for General Motors Health Care Initiatives; the formerly director of operations of the California Public Employees' Retirement System (CalPERS) Health Benefits Program; a senior manager of the Office of Personnel Management (OPM), which oversees the Federal Employees Health Benefits Program (FEHBP); and the Executive Director of Policy and Public Affairs for the Buyers Health Care Action Group (BHCAG), Minneapolis, Minnesota.

Standardization of the benefit package on which plans bid is a very limited regulatory step. CPAC concluded that a standardized benefit package on a basic package of benefits was a necessary step to facilitate comparison of bids across plans, to provide beneficiaries with comparative information on managed care alternatives, and to avoid threats of risk selection.

5.3 Expanding producer and consumer choice: unlimited supplements, benefit enhancements by low bidders, and mid-cycle corrections

Given that the demonstration design incorporated a standardized benefit, CPAC thought that it was especially important to develop other ways to enhance consumer and producer flexibility. The committee thus selected certain other provisions with this goal in mind:

- Plans can offer unlimited supplemental (add-on) benefits at their discretion -Outside the basic, standardized package, CPAC emphasized that plans were
 to be allowed to offer any supplementary benefits they wanted, at any
 supplementary premium they wished to charge. As noted, the primary
 constraint was that these supplements had to be add-ons to the standard
 benefit. They could not substitute for the standard package. Thus, while the
 basic benefit package was protected thus satisfying the minimal needs for
 competition plans were to have virtually unencumbered flexibility to add
 benefits to the standard package (e.g., to offer extra benefits to compete with
 Medigap insurers in their area). So, too, for consumers: once plans have
 fulfilled the basic requirements for bidding, beneficiaries should be able to
 purchase additional benefits with their own money if they so desire.
- Low-bidding plans can enhance their standard benefit packages in any way that they choose, including a premium rebate In the CPAC model for the demonstration, the government contribution is set higher than the lowest bid. As a result, there needs to be some incentive for lower-priced plans to bid low (otherwise, such plans will tend to bid at the expected value of the government contribution, rather than their costs). To create such an incentive, CPAC established provisions to allow low bidders to enhance their standard benefit packages, offer premium rebates (a provision added late in the demonstration), or simply retain the difference between their bid and the government contribution. Competition among health plans makes it unlikely that plans will keep very much of the surplus, thus making it likely that low-bidding plans will offer expanded benefits or cash, thereby expanding consumer choice.

To be sure, this provision for low bidders means that the standardization of the basic benefit package is being relaxed. But it is being done in a way that enhances, rather than undermines, competition, as it: a) increases the incentives for plans to bid low, b) supplements (adds onto) the basic,

standardized benefit, rather than replaces it, and c) preserves the standard benefit package as the basis for comparing bids.

Six months into the bidding cycle, any plan can enhance its benefits in any way – A final measure to enhance plan and consumer choice was to allow all plans to enhance their benefits in any way they chose, half-way through the bidding cycle. This provision permits all plans (high bidders as well as low bidders) to formulate mid-stream adjustments between annual bids. This mid-course correction alternative meant – in effect – that benefits would no longer be fully standardized after the mid-cycle adjustments. But these changes were not an arbitrary relaxation of the standardization requirement. The CPAC believed that retail competition using a standard benefit package during the open enrollment period would provide the market discipline necessary for plans to price the standard benefit package accurately and to decide which supplementary benefits to offer at what premium. The mid-course correction was set to occur after the key purposes of the standardized benefit were achieved in the bidding process. In any event, these mid-cycle changes were to be enhancements to the basic benefit, not reductions. 38

These provisions thus represented efforts by CPAC to facilitate plan and consumer choice and enhance competition, without undermining the reasons that a standardized benefit was chosen in the first place.

5.4 CPAC action on alternatives to allow high-bidding plans to avoid charging a premium

The CPAC model provides that all plans bid on a standard package, and high-bidding plans must charge a premium. The risk of having to charge a premium is one of the major incentives for plans to bid low (the other being the opportunity of low bidders to enhance their standard benefits, as described above). Given the concerns of all parties to minimize beneficiary disruption, are there alternatives available to allow high bidding plans to avoid having to charge a premium, but still maintain incentives to bid low?

This issue is itself outside the question of standardizing the benefit package, except that some of the options for allowing high bidders to avoid charging a premium involve changes in the standard benefit package. Accordingly, we will consider this issue here. Three options have been suggested to permit waiver of premiums by high-bidding plans: allowing waiver of nuisance premiums, allowing high-bidding plans to take a cut in

³⁸ It is worth noting here that, if the Demonstration is not implemented until 2002 (the earliest possible date under current legislation), the mid-cycle adjustments provided in the CPAC design will be less relevant. The reason: in 2002 under the BBA, beneficiaries will be "locked" into their health plan choices between open enrollment periods, except for a 6-month window during which beneficiaries can enroll/disenroll for any reason. The 6-month window becomes a 3-month window in 2003. The mid-cycle adjustments the demonstration provides will be of less use, as this window shrinks from 12 months per enrollment year (current policy), to 6 months, to 3 months.

reimbursement, and (suggested by Congress) allowing high-bidding plans to increase the percentage of out-of-pocket costs. We consider each in turn below.

5.4.1 Waiving nuisance premiums

The basic concept of a nuisance premium is that some premiums are too small to collect – e.g., because costs of collection are more than the expected revenue, even as the requirement to pay the premium is at least a modest disruption to beneficiaries. One alternative to deal with this version of beneficiary disruption is to allow high-bidding plans to waive the premium if their bids are within a "nuisance" threshold. The Kansas City and Phoenix AACs both tentatively established the nuisance premium threshold at \$10 per member per month. Nuisance premiums were not part of the original CPAC design, but both Kansas City and Phoenix AACs argued (and CPAC agreed) that allowing the waiver of nuisance premiums would usefully streamline demonstration financial arrangements and avoid inconveniencing beneficiaries, albeit at the cost of a slight reduction in the incentive for plans to bid low and a corresponding increase in bid prices. On balance, the benefits of this choice appeared to the CPAC to outweigh the costs.

5.4.2 Allowing high-bidders to take a reduction in reimbursement

A second alternative for high-bidding plans to avoid a premium is to allow such plans to waive their premium in exchange for a lower government contribution. Plans would lose two dollars of revenue for every dollar of premium they waive (\$1 of premium and \$1 of government contribution). This penalty is required to maintain some incentive for plans to submit low bids. If plans lost only the dollars of premiums they waived, they would simply submit high bids.

CPAC considered this option and rejected it. The premium waiver with a penalty (also called the "Denver design" because it was proposed, at the suggestion of health plans, for the demonstration in Denver, Colorado, in 1997) is thought to be plan-friendly, because it gives high bidders an option to avoid charging a premium. However, at the CPAC meetings, there was very little public support for the option, from health plans or anyone else. At the same time, this option has two disadvantages. First, this option reduces plans' incentives to bid low. Second, this option suffers from an important conceptual problem: a plan that accepts a penalty in lieu of a premium would be reducing its revenue below the level that – according to its bid – the plan needed to cover its costs. As a result, the plan would be providing services for less than its apparent costs, with troubling implications for the quality of beneficiary care.

CPAC's formal recommendation in its original design – a decision reaffirmed at the CPAC meeting in October 1999 – was not to allow the premium waiver. This option's disadvantages substantially outweigh any benefits.

January 19, 2001 Page 88

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³⁹ Roger Feldman, "Note on the Denver Design," unpublished paper prepared pursuant to HCFA Contract No. 500-92-0014, DO5 (April 15, 2000).

5.4.3 Allowing high-bidders to reduce elements of the standard benefit

A third option for high bidders to avoid charging a premium is to allow plans to reduce their out-of-pocket premium if they are willing to cut particular elements of the standard benefit package. In other words, a benefit cut is substituted for the Denver option's reduction in the government contribution. Congress suggested one version of this option, whereby a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium. CPAC interpreted this option as allowing health plans to offer reduced coverage (e.g., a plan with higher coinsurance, copayments, or deductibles) in lieu of charging an out-of-pocket premium. An important question is whether the reduction in coverage would be proposed by CPAC or by the health plans themselves. As discussed below, neither CPAC nor HCFA has the data required to create an accurate schedule relating reductions in coverage to reductions in premiums. On the other hand, allowing health plans to propose their own reductions creates perverse incentives for bidding.

This option has the potential to increase the diversity of products on the market. It also gives high bidders a way to reduce their costs (by reducing benefits to the level of the government contribution), so that plan revenue and costs are at least theoretically made equal (unlike the Denver option, for which, in principle, the plan accepts a reduction in revenue below the level of its costs). In this latter sense, the option of reducing the standard benefit is at least more stable for the long term than the Denver option.

But this option imports a series of important disadvantages. Most important, it would substantially undermine the original purposes of standardization:

- Reduced incentives for low bids –This option would be equivalent to a second round of bidding. Plans could submit high bids, knowing that they could adjust their benefits in subtle ways, after seeing their competitors' bids. This option thus would substantially reduce the incentives for plans to bid low.
- Administrative complexity and the reduced comparability of bids This option would increase the administrative complexity of the bidding process, and hence would be less practical as a national model. The comparison of bids would no longer be against a common standard benefit. HCFA would have to provide careful actuarial review of all benefit adjustments. Those adjustments would require data on utilization and costs within M+C plans, and the effect of changes in benefits on the risk mix of enrollees in each plan. HCFA currently does not have anything like the data necessary for those estimates. In these terms, this option is similar to the option of having no standard benefit package whatsoever. The primary difference is that, in principle, fewer plans (only high bidders) deviate from the standard package, but for those deviating cases, the challenge and the problems would be similar to the absence of any standard package.
- Reduced comparability of plans for consumers Beneficiaries no longer could assume that all plans offered at least the standard benefit package.

Threats of risk selection – This option would give plans a greater opportunity to use benefits to influence risk selection. Plans might substantially increase the point-of-service costs of blood transfusions and other benefits especially important to sicker populations, for example. The opportunity to make that benefit reduction would provide plans an incentive to bid high.

The particular version of this option proposed by Congress (allowing plans to charge a higher percentage of out-of-pocket costs in exchange for a lower premium) does not avoid any of these difficulties, although it would moderate some of them. For example, if the only benefit reduction that plans could make was to increase point-of-service costs, the administrative difficulties of reviewing bids might be lessened, although still considerably more complex than required for comparing bids all based on a standard benefit and still beyond current HCFA data capabilities.

Thus, allowing plans to reduce their benefits to avoid a premium would undermine most of the advantages of standardization during the settlement of prices and benefits – when standardization is most needed to enhance competition. For reasons outlined in Section 5.2, CPAC concluded that, on balance, the advantages of standardization outweighed the disadvantages at that stage of the bidding process.

5.5 Setting the level of the benefit

If CPAC concluded that standardization was needed, the question remains at what level the benefit should be standardized. This is an especially important question for Medicare, and it relates directly to one of the issues raised by Congress, concerning the nature and extent of the benefit to be required of plans in the demonstration. Medicare is an entitlement, and entitlement principles permeate any discussion of Medicare benefit packages, for this demonstration or other purposes. Strictly speaking, what Medicare beneficiaries are entitled to is the statutory list of covered Medicare benefits – a truly standard benefit package. However, Medicare's contracts with private, Medicare+Choice (M+C) health plans can be made or dissolved on an annual basis and carry no guarantee of availability. In areas of the country where M+C plans offer benefit packages for zero premium that are more generous than the entitlement, beneficiaries have become accustomed (if not strictly entitled) to these enhanced benefits. Thus the question: at what level should the standard benefit package be set?

The CPAC concluded that beneficiaries in demonstration market areas with above-entitlement benefits should continue to receive something at least approximating the same level of benefits that they would get in the absence of the demonstration. Beneficiaries in these areas have made financial plans and built expectations around the protections the enhanced benefits provide. Although not an entitlement in any legal sense, these expectations deserve some respect. At the same time, under the demonstration these beneficiaries were going to be asked to join a test that might inconvenience them (e.g., to change health plans) or cost them money (e.g., an increase in premiums to keep their current plan), in addition to causing some generalized anxiety. To minimize this disruption, the

CPAC concluded it was essential to offer beneficiaries in these areas the relative certainty of a benefit package approximating the norm for the market in the absence of the demonstration. ⁴⁰ The effect of this choice was that the baseline benefit package under the demonstration would be: (1) no different than what plans would have offered without the demonstration, and (2) available from at least some plans for zero premium.

If the market norm established an approximate target for the benefit package in demonstration areas, CPAC also considered where the floor for the benefit should be established. One possibility was obvious: the statutory entitlement. But CPAC viewed the statutory entitlement to be an unrealistic floor for the demonstration benefit, even in low payment areas. CPAC endorsed instead the statutory entitlement plus a minimum \$500 outpatient drug benefit because the committee wanted:

- To ensure that the standard benefit package did not fall too far below the market norm in high payment areas.
- To move toward a degree of standardization of M+C benefits nationwide, against the backdrop of AAPCC/BBA payments that created wide variability in benefits among areas. Competitive pricing could correct that variability. Although, under the budget neutrality constraint, the demonstration realistically could not be conducted in low-payment/low-benefit areas, the benefit package for the demonstration should be a model generalizable to such areas.
- To underscore the clinical importance of an outpatient drug benefit as part of a modern Medicare benefit.
- To make the Competitive Pricing Demonstration a possible test for a national policy, since all serious Medicare reforms contemplate adding some version of an outpatient drug benefit.

Thus, the committee established a floor for the benefit package, as well as a target level. In effect, the higher of these two levels defined the benchmark for setting the standard benefit. High-payment areas would be minimally disrupted under this rule. Low-payment areas would receive additional funds and move closer to the national norm, when and if the demonstration could be run there.

⁴⁰ One complexity in specifying this benefit was to figure out how the effects of the 1997 BBA on payment levels would be reflected in the benefit packages offered by health plans. The BBA tended to compress real payment levels in the high-payment areas where the demonstration was being tested. In order to preserve budget neutrality, the AACs had to estimate the benefits plans would offer under the reduction in future reimbursement under BBA.

5.6 The role of the AACs in setting the standard benefit package

The final issue to consider in thinking about the benefit package is how it gets set and who participates in setting it. The BBA made clear that local advisory committees were to play an important role in the implementation, as a vehicle to bring the interests and concerns of local stakeholders to bear on demonstration plans. CPAC believed that the specification of the benefit package was one of the most important ways that the AACs could fulfill that role. Like the CPAC, the AACs included representatives from major stakeholder groups, but with a higher proportion of beneficiary and health plan representatives than the national body.

There were three important reasons to give the AACs this role. First, the delivery of health care services, and the expectations of beneficiaries, vary from one market area to another. For example, some areas might be more oriented to outpatient treatment, or home care, than others. It is important to be close to the locality to know the critical details of how benefit choices would play out in the local market. The local AAC was in a much better position than the CPAC to know the expectations of beneficiaries in the local market areas and hence to weigh alternative specifications of the market norm. Using a local body in this role was one of the best ways available to minimize beneficiary disruption. Second, if the local community was to "buy into" the demonstration, they needed to have a role in setting some critical parameters. The benefit package was one of the best ways to give communities that leverage. Finally, using the AACs in this way fit naturally with the AAC's efforts to educate beneficiaries about the demonstration. The Phoenix AAC in particular used the specification of the benefit package as an occasion for "town halls" and focus groups that served to inform the AAC about beneficiary preferences, but also to educate beneficiaries about the demonstration and what it portended.

The use of AACs to set the standard benefit was not without problems. Not least, it proved difficult to give the AACs discretion over the standard benefit package without simultaneously allowing them to add benefits up to the budget neutrality constraint (i.e., current spending levels). In other words, giving local bodies control over the benefit package naturally asserted local interests in maintaining funding levels to these communities. But these problems are minor compared to the accomplishments of the AACs: in two very different communities amidst important political controversies, AACs were able to bring local perspectives to bear on benefit choices, and could successfully and expeditiously reach agreement on a common benefit to require of all plans.

Exhibits 5.1, 5.2 and 5.3 present the results. Exhibit 5.1 below offers a selective comparison of benefits in the two demonstration sites. Exhibits 5.2 and 5.3 at the end of this chapter present the standard benefit packages for Kansas City and Phoenix that were incorporated in draft bid solicitation packages for each city. ⁴¹ These latter exhibits differ

January 19, 2001 Page 92

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⁴¹ The Kansas City benefit summary shown in Exhibit 5.2 is from the original bid solicitation package in Kansas City, which was completed in June 1999. The Kansas City AAC continued to refine its standard packages after the demonstration was delayed in mid-1999, but a new package had not been completed at the time the demonstration was cancelled in November 1999. The bid package shown for Phoenix is from the draft bid solicitation package for Phoenix that was under review at the time the demonstration was cancelled.

from each other in structure and appearance because the Kansas City and Phoenix AACs chose to do their work and to present the results in somewhat different ways. The two exhibits reflect some important differences in philosophy and details, summarized in Exhibit 5.1. In particular:

Exhibit 5.1. Medicare Competitive Pricing Demonstration: Selective comparison of Kansas City and Phoenix Standard Benefits

Benefit	Kansas City provision	Phoenix provision	
Ambulance	\$25, including ambulance service resulting in hospital admission	\$0	
Cafeteria benefit	None	Benefits worth 1 percent of actuarial value of bid must be included	
Inpatient hospital admission copayment	\$0	\$50	
Physician visit copayments	\$12 (PCP)/\$17 (specialist)	\$10 for PCP or specialist	
Other outpatient copayments – e.g. chiropractic, podiatry, hearing exam	\$12 (PCP)/\$17 (specialist)	\$10	
Prescription drug cap	\$1,000 per year, for single- or multiple- source drugs	\$2,000 for brand-name drugs Unlimited for generics	
Rate drugs charged against cap	Single source: AWP – copay Multiple source: Acquisition cost – copay	Brand name: AWP - copay	
Prescription drug copayment	\$10 multiple source/\$20 single source, 30-day supply	\$8 generic/\$18 brand, 30-day supply	

- <u>Phoenix</u> For example, the basic copayments for most outpatient services were \$12/\$17 in Kansas City (for primary care physicians and specialists, respectively), versus \$10 in Phoenix for both PCPs and specialists. This difference in copayments appeared to be due to the effects of the budget neutrality constraint in Kansas City, rather than any difference in approach to utilization incentives. ⁴² But Kansas City chose to accommodate that need by higher copayments, rather than by reducing other areas of coverage believed to be of greater importance to beneficiaries notably outpatient prescription drug coverage (see below).
- The outpatient prescription drug benefit was far more generous in Phoenix than Kansas City The drug benefit in Phoenix was capped at \$2,000 (for brand name drugs) and unlimited (for generics). The Kansas City drug benefit was capped at \$1,000 for both types of drugs, although multiple-source drugs (analogous to the generics of the Phoenix benefit) were charged against the cap less heavily. This difference between the two cities again appears to be a consequence of budget neutrality limitations. (The Phoenix

Thus, both Exhibits 5.1 and 5.2 should be viewed as preliminary, with the Phoenix exhibit reflecting somewhat later information.

⁴² That is, Kansas City copayments were not raised to deter utilization, but were set at a level deemed by actuaries to preserve budget neutrality, given other elements of the package.

benefit was more expansive before the demonstration as well.) Kansas City chose more limited coverage in other areas (e.g., the higher copayments noted above) in order to maximize the drug cap that was feasible given the budget neutrality constraint.

Phoenix included a "cafeteria benefit" as part of their standard package, to increase plan flexibility — Phoenix required plans to specify additional benefits as part of their bids, actuarially equivalent to 1 percent of their bids. These additional benefits could be anything the plan chose. The AAC apparently considered this provision useful because it was difficult to fit — within the contours of a standard benefit — all of the attractive extra benefits (e.g., exercise programs) that plans were accustomed to providing and beneficiaries apparently liked. This cafeteria provision had the effect of giving plans flexibility around the edges of an otherwise fixed benefit — i.e., some useful additional flexibility without losing the benefits of standardization. The cost of a provision like this is that it obviously increases bids by the percentage amount of the requirement. The Phoenix AAC considered the benefits to be worth the cost, and that community had enough room under the budget neutrality constraint to add this requirement.

It is obvious that a key constraint in all these benefit decisions was the requirement of budget neutrality. In both Kansas City and Phoenix, a fairly disciplined process was used to enforce the budget neutrality requirement. In broad terms, the process reflected the following steps:

- 1. The AACs examined existing benefit packages for M+C plans in the demonstration area.
- 2. The AACs developed a "first-cut" standard benefit package, by looking for common denominators among existing benefits and reasonable compromises where benefits were less uniform.
- 3. Actuaries were provided to the AACs under HCFA's primary consulting support contract for the demonstration. The actuaries estimated the cost implications of the AAC's tentative choices, leading to revisions in the packages by the AAC, re-estimations by the actuaries, and so on back and forth. Actuaries also provided "tradeoff analyses" to each committee, showing how much of one benefit (e.g., additional dollars on the outpatient prescription drug cap) could be added by reducing another benefit (e.g., requiring an additional dollar for outpatient physician and other copayments).

In this fashion, the AACs worked up to the actuarially estimated budget neutrality limit, using various tradeoff methods to arrange and rearrange benefits into a package that both satisfied the budget neutrality constraint and met the concerns of the committee.

It thus was feasible to develop a standard benefit package on which local stakeholders could agree and to do so within the demanding budget constraint imposed on these demonstrations. Even in the politicized environments in both of these cities, a reasoned conversation between beneficiary advocates and actuaries (never easy!) was able to take place; and the discipline of budget neutrality was maintained.

5.7 Benefit structure issues: summary and conclusion

Decisions concerning the nature and scope of the benefit package were among the most difficult of the entire demonstration. Reasonable opinions can certainly differ on these issues, but the CPAC found that, on balance, the considerations were most compelling to arrange the benefit structure as detailed in this chapter. A summary of the CPAC's conclusions, in relation to the questions asked by Congress, is as follows:

1. The nature and extent of the benefit structure that should be required of plans participating in the project and the rationale for such benefit structure.

The most important elements of the CPAC's judgments in this area are, first, to structure the bidding around a standardized benefit package. The committee concludes on balance that the competitive process should be based on a standard benefit package, as a way to facilitate comparison of bids by HCFA, facilitate comparison of benefits by beneficiaries, simplify administration (important if the demonstration was to be generalized), and reduce the potential for risk selection in enhanced competition.

Second, the committee concludes that the benefit should be set at enhanced levels that constitute the market norm for the demonstration areas. To minimize beneficiary disruption, the committee concludes that the enhanced benefits common in higher payment areas should be respected in the demonstration. In any event, a minimum benefit (including \$500 outpatient prescription drug coverage) should be required, in order to move toward a degree of standardization of M+C benefits nationwide, to underscore the clinical importance of an outpatient drug benefit as part of a modern Medicare benefit, and to make the Competitive Pricing Demonstration a possible test for a national policy.

2. The potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project.

Standardization has many benefits noted throughout this chapter. But it also has costs, and the committee concludes that there are important means available to moderate those costs. After the government contribution to premiums is set for the core benefit package and all core and supplemental packages are settled, it is possible to find ways to enhance producer and consumer choice. CPAC actively pursued those options, by allowing unlimited supplementary benefits, giving low bidders the option to offer benefit enhancements or premium rebates, and giving all plans the option to make mid-cycle enhancements in their benefits.

3. The potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be).

CPAC welcomes variations on standardized benefit packages that promise to enhance competition, Thus, the committee fully supports granting low-bidding plans the option to offer rebates up to the level of the Part B premium amount.

However, CPAC believes it important to avoid changes in the benefit package that promise to undermine competition in the bidding for the basic benefit package. In particular, the committee has repeatedly rejected the Denver option of allowing plans to waive premiums in return for a payment penalty; and the committee finds the prospects of benefit reductions by high-bidding plans a threat to the basic competitiveness of the bidding, undermining all of the reasons the committee chose to standardize the benefit package. The committee did, however, approve the AAC suggestion to streamline the premium collection requirements, so that only fairly substantial premiums (>\$10 per month) are collected. The CPAC also approved the Phoenix proposal to include a 1 percent cafeteria benefit that could be devoted to any additional benefit the plan chose.

In order to make some of the difficult choices needed to specify a standard benefit – especially in a demonstration, at a time when there is no Medicare experience with this process – CPAC delegated discretion within defined parameters to the AACs. The effectiveness of this choice is reflected in the fact that both AACs succeeded in specifying standard benefits that took into account local concerns.

Overall, the CPAC's benefit decisions reflect a commitment to maintaining benefit levels in the demonstration, standardizing the benefit package for the core competition, facilitating local discretion over implementation, and avoiding options (e.g., benefit reductions for high bidders, in lieu of premiums) that might have certain desirable properties but threaten to undermine the incentives for plans to compete. Meanwhile, the committee supports alternative means to enhance beneficiary and producer choice (e.g., premium rebates and unlimited supplements) that actually serve to reinforce the competitive process. The important point in all these decisions is to recognize that adequate incentives for price competition cannot be taken for granted, but that careful steps can be taken to address some of the costs of key decisions (e.g., the effects of standardization for a basic benefit can be moderated by attention to expanding choices on supplements and enhancements by low bidders).

Exhibit 5.2. Medicare Competitive Pricing Demonstration: Kansas City Demonstration Area — Standard Benefit Package

Area — Standard Benefit Package					
Benefit	Co-Pay	Co-Pay	Limit	Limit	Limit
Ambulance, including Ambulance resulting in a hospital admission	\$25				
Chiropractic services	\$12 (PCP)	\$17 (Specialist)			
Durable Medical Equipment, Orthotics, Prosthetics, and related supplies	\$0				
Emergent/Urgent, ER Non-Plan Hospital	\$50				
Emergent/Urgent, ER Plan Hospital	\$50				
Emergent/Urgent, ER Services Resulting in Admission	\$0				
Emergent/Urgent, Non-Plan Urgent Facility	\$25				
Emergent/Urgent, Plan Urgent Facility	\$25				
Emergent/Urgent, Urgent Care in a Physician's Office	\$12 (PCP)	\$17 (Specialist)			
Emergent/Urgent, Urgent Care Resulting in Admission	\$0				
Health Education			Additional education		allowed
Hepatitis B Vaccination	\$0	\$0			
Home Health (per visit)	\$0				
Inpatient Hospital (per admission)	\$0				
Inpatient Mental Health (per admission)	\$0	20	No Extra	ι Benefits	
Mammogram	\$0 (PCP)	\$0 (Specialist)			
Non-emergency Transport		No Benefit			
OT/PT (per treatment)	\$12				
Out-of-Area, Out-of-Country (world-wide urgent and emergency services)			Yes		
Out-of-Area, Out-of-Plan (covered for urgent and emergency services only)			Yes		
Outpatient Hospital (per visit)	\$0				
Outpatient Lab (per visit)	\$0				
Outpatient Mental Health (per session)	\$17 (Group)	\$17 (Individual)			
Outpatient Rehab (per visit)	\$12				
Outpatient X-Ray (per visit)	\$0 \$0	\$0			
Pap Smear	(PCP)	(Specialist)			
Physician Visits	\$12 (PCP)	\$17 (Specialist)			
Podiatry Services	\$12 (PCP)	\$17 (Specialist)			Madeal
Prescription Drug Cap, per year, applies to both Single Source and Multiple Source Drugs. After Cap is met, prescriptions may continue to be purchased from a participating pharmacy at the lesser of the average wholesale price or the retail price.			\$1000 Per Year	Single Source Drugs charged against cap at AWP less co-pay	Multiple Source Drugs charged against cap at acquisition cost less co- pay
Prescription Drug Formulary			Formula	y Allowed	
Prescription Drug, Single Source	\$20		30-day	Supply	

Exhibit 5.2. Kansas City Demonstration Area — Standard Benefit Package [continued]

Benefit	Co-Pay	Co-Pay	Limit	Limit	Limit
Prescription Drug, Multiple Source	\$10		30-day Supply		
Prescription Drug, Mail Order	\$20 (Multiple Source)	\$40 (Single Source)	90-day Supply		
Routine Dental Services (preventive exams and cleaning)No Benefit			No Benefit		
Routine Hearing Exams and Hearing Aids	\$12 (exam) (PCP)	\$17 (exam) (Specialist)	1 exam per year	\$500 hearing aid allowance	1 hearing aid per 3 years
Routine Physical Exams	\$12		1 per year		
Routine Vision Services, Eye Exam	\$12 (PCP)	\$17 (Specialist)	1 per year		
Routine Vision Services, Eyeglasses or Contacts	\$0		\$70 allowance per year		;
Skilled Nursing Days 1-20 (per day) (3-day prior hospital stay is not required)	\$0				
Skilled Nursing Days 21-100 (per day)	\$0		No Extra	Benefits	
Travel Benefit			No Benefit		

Note: The above benefit description reproduces the description of the standard benefit that was part of the bid solicitation package distributed to Kansas City M+C plans in June 1999.

Source: Health Care Financing Administration, "Medicare Competitive Pricing Demonstration: Bid Solicitation Package for Kansas City 2000," June 1999, Appendix B.

Exhibit 5.3. Medicare Competitive Pricing Demonstration: Phoenix Demonstration Area — Standard Benefit Package

Benefit	Coverage Definition	Benefit Copayment	Network/Access
Ambulance Service	Same as Medicare	\$0	Plans do not require prior authorization for emergency services in or out of service area. Plans require prior authorization for all other ambulance services.
Blood Services	Same as Medicare.	\$0 for inpatient and outpatient	Pre-authorization required.
Cafeteria Benefit	Plans must include 1% actuarial value in benefits.		
Chiropractic Services	Same as Medicare.	\$10	Requires pre- authorization.
Clinical Diagnostic Laboratory Test	Same as Medicare	\$0	All plans require prior authorization.
Dental Services	Same as Medicare plus one annual exam and x-rays and two cleanings per year.	\$10 exam and x-rays \$20 cleaning	Contracted dentist must be used.
Durable Medical Equipment (DME)	Same as Medicare	\$0	Must be prescribed by plan physician.
Emergency and Urgent Care Services	HCFA model definition.	\$50 emergency - waived if admitted to the hospital. \$15 urgent care	No pre-authorization required.
Eyeglasses, Frames, and Contact Lenses	Medicare plus \$50 annual allowance.	\$50 annual allowance	Must use contacted provider; self-referral.
Flu and Pneumococcal Vaccine	Same as Medicare	\$0	No pre- authorization required.
Hearing Exam and Aids	One exam per year.	\$10 exam	Exam may be self-referred.
Hepatitis B Vaccine	Same as Medicare.	\$0	Pre-authorization required.
Home Health	Same as Medicare Plans may provide this benefit as an alternative to hospital/SNF care. See C-10 for prescription drug coverage.	\$0	All plans require prior authorization.

Exhibit 5.3. Phoenix Demonstration Area — Standard Benefit Package [continued]

Benefit	Coverage Definition	Benefit Copayment	Network/Access
Hospice	Same as Medicare Note: This benefit is paid by Medicare not the health plan. During the time the hospice election is in effect, HCFA=s capitation is reduced or eliminated. The health plan must supply only those plan benefits that are not the responsibility of the hospice provider.	\$0	All plans require prior authorization.
Impatient Mental Health	Same as Medicare	\$0	All plans require prior authorization.
Inpatient Hospital Coverage	Medicare coverage plus coverage for 365 days.	\$50 for affiliated and non- affiliated hospitals	Pre-authorization required.
Inpatient Skilled Nursing Facility	Same as Medicare. Plans waive the 3 day hospital requirement.	\$0	All plans require prior authorization.
Liver, Heart, Cornea, and Bone Marrow Transplants	Same as Medicare.	\$0	Pre-authorization required.
Mammography, Prostate, and Colorectal Screening	Annual screenings for mammogram. Same as Medicare for Prostate/Colorectal.	\$0 for screening Note: Copayment for physicians visit applies.	No pre-authorization for mammogram. Pre-authorization is required for other screening.
Out of Country Services	World wide coverage for emergent and urgently needed care.	\$50 emergency room \$15 urgent care center or physician office	No pre-authorization required.
Outpatient Hospital/Surgical Services	Same as Medicare.	\$10 for hospital and surgical	Pre-authorization required.
Outpatient Mental Health Including Alcohol and Chemical Dependency	Same as Medicare, plus outpatient alcohol and chemical dependency programs.	\$10 individual \$5 group	May self-refer to behavioral specialist within network.
Outpatient Occupational/ Physical Therapy/Speech, Hearing and Language Disorders	Same as Medicare. No maximum for services received from an independently practicing Medicare approved physician or occupational therapist.	\$10	Pre-authorization required.
Pap Smear Screening, Pelvic Exam	Medicare coverage plus annual exam.	\$10 physician visit not for pap smear	May self-refer to plan network.
Patient Education	Same as Medicare.	\$0	
Physician Services	Same as Medicare plus annual routine physicals and routine immunizations.	\$10 for PCP or specialist	

Exhibit 5.3. Phoenix Demonstration Area — Standard Benefit Package [continued]

Benefit	Coverage Definition	Benefit Copayment	Network/Access
Podiatry	Same as Medicare.	\$10	Requires PCP referral.
Prescription Drug/ Monthly Supply	Drugs obtained through the formulary.* Brand name drugs obtained when there is a generic equivalent: Member pays the <i>brand-name</i> copayment plus the difference in cost between the generic and the brand-name drug.*** If drug cost is less than copayment, the usual and customary cost for the drug is charged and drug cost does not count toward the cap.	\$8 Generic \$18 Brand 30 day supply Brand name drug annual cap \$2000**. Generics unlimited/no cap.	Plans can establish precertification requirements.
Prescription Drug/Mail Order	Drugs obtained through the mail order formulary.*	\$16 generic \$40 brand 90 day supply	Plans can establish their own pre-certification requirements.
Prescription Drugs/ Calculation of Maximum Limit	Brand name: Average Wholesale Price (AWP) minus copayment. Dispensing fee not included in calculation.		
Renal Dialysis and Kidney Transplant	Same as Medicare.	\$10 for outpatient \$50 for inpatient or non- affiliated hospital	Requires pre- authorization.
Routine Vision/Eye Exam	One exam per year including refraction.	\$10	Must use contracted provider; self-referral.
Transportation	None		
X-Ray Services	Same as Medicare.	\$0	Requires pre- authorization.

NOTES:

The above benefit description reproduces the description of the standard benefit that was part of the draft bid solicitation package reviewed by the Phoenix AAC at its November 9, 1999, meeting, just before Congress stopped the demonstration at that site.

Source: Health Care Financing Administration, "Medicare Competitive Pricing Demonstration: Bid Solicitation Package for Phoenix 2000 [DRAFT]," November 1999, Appendix B.

The heath plan's formulary must include at least one drug in all the essential classes of drugs. Note: The plan must include at least one drug as defined on the list approved by the committee. \$2000 brand name drug cap applies to mail order and monthly supply.

^{***} At the time the demonstration was stopped by Congress, the Phoenix AAC's Drug Sub-committee planned to define how the cost of drugs would accumulate to the brand name cap when generics were not available.

Chapter 6.

Recommendations

After weighing the experience of the Competitive Pricing Demonstration to date, the purposes that the demonstration was designed to serve, and the issues raised by Congress in the 1999 Balanced Budget Refinement Act and addressed by the CPAC in the report chapters above, CPAC concludes the following:

1. A Competitive Pricing Demonstration designed by CPAC should go forward, but only if budget neutrality is suspended. Congress should give CPAC the flexibility needed to devise creative solutions to the problems that competitive pricing presents.

One of the key goals of the Competitive Pricing Demonstration is to test the implications of shifting Medicare prices to a market-like basis – ultimately including M+C and FFS, as appropriate. But the demonstration should not *start* by including FFS as a bidding health plan. At the initial sites and in the initial years, the demonstration should proceed with the partial inclusion of FFS currently reflected in the CPAC design – i.e., with premium rebates in a bidding process confined to M+C plans – but only if budget neutrality is suspended.

As is obvious from the issues raised throughout this report, CPAC would be able successfully to take on the challenges of competitive pricing only if the committee is given more flexible tools to resolve the substantive and political difficulties that have thwarted this effort to date. Chief among these tools would be a suspension of the budget neutrality requirement, to permit more forthright compensation of beneficiaries in test areas. As noted in Chapters 1 and 2, there in fact are ways to create supporters and winners from competitive pricing:

- Pick low-payment sites, where the competitive price for the CPAC-enhanced benefit (i.e., the entitlement plus \$500 outpatient drug coverage) would be above the current government payment amount.
- Promise benefit stability over the five years of the demonstration, to protect demonstration beneficiaries against the benefit reductions likely in nondemonstration areas that currently have high payment levels.
- Offer lump-sum payments to hold beneficiaries harmless from or, at least, to moderate the costs that beneficiaries might incur under the demonstration (e.g., to moderate the effects of higher premiums for certain high-bidding plans).

All of these options would require additional funds beyond the budget-neutral amounts in candidate sites. It is difficult to create options to resolve the political conflicts to date that

do not involve more funds. The costless options (e.g., regulatory relief) have already been explored, although CPAC remains open to consideration of new design alternatives.

2. The design and implementation of the Competitive Pricing Demonstration should continue to be done using the consultative arrangements established by Congress in the BBA. However, in these future efforts, the CPAC and AACs should have means available to consult with and better understand the concerns of Congress.

It is not easy to design and implement a demonstration through panels of experts and stakeholders, acting in public and with public participation. But precisely that kind of process has been an effective way to integrate disparate interests in the Competitive Pricing Demonstration, notwithstanding the political controversies surrounding competitive pricing issues, the sometimes sharp divisions of opinion on the committee, and the complex constraints under which the committee operated. Meanwhile, the work of the AACs provided a practical mechanism to adapt national competitive pricing models to variations in local circumstances and preferences. For example, in order to make some of the difficult choices needed to specify a standard benefit, CPAC delegated discretion within defined parameters to the AACs. Both AACs succeeded in specifying standard benefits that took into account local concerns.

These methods have been shown to work well, but for key constraints that the demonstration had to satisfy and political difficulties that the demonstrations encountered. Moving forward, CPAC believes it is essential for means to be established to permit the CPAC to enter into a more sustained dialogue with Congress, so that the creative design efforts of the CPAC can proceed within the bounds of the consensus that Congress develops and maintains.

3. If Congress would like FFS included in the demonstration, it should give CPAC explicit authority to do so.

CPAC had no alternative but to exclude FFS (as a bidding plan) from the demonstration, since the Balanced Budget Act of 1997 made no reference to demonstrating a competitive payment system for traditional FFS Medicare. In any event, the terms of FFS Medicare are the essence of the Medicare entitlement, requiring, in CPAC's judgment, an explicit Congressional mandate to change.

CPAC looks to Congress for direction on whether or not to include FFS in the demonstration, in light of the various considerations outlined in this report and elsewhere. If Congress approves inclusion of FFS as a bidding plan in the demonstration, CPAC will expand the scope of its work accordingly.

4. The demonstration needs more enduring political support from Congress.

The interests at stake in the Competitive Pricing Demonstration are fundamental and require continuing Congressional engagement to withstand the inevitable controversies of

any steps to reform. CPAC cannot take the lead in putting the needed consensus together. Neither can HCFA. Only Congress is in a position to build the necessary consensus.

5. Competitive pricing may offer some unique advantages for bringing M+C plans to rural areas, but to do so would require budget flexibility and the need to experiment with different demonstration designs than are applied in urban areas.

CPAC remains interested in exploring the possibility that the primary policy levers at its disposal – the level and structure of payment to M+C plans and FFS providers – could lead to improvements in the health care delivery system in rural areas. But the problems of availability and access to healthcare resources in rural areas are not simply problems of payment rates. In any event, a demonstration in rural areas would need to experiment with different demonstration designs than have been proposed for urban areas – e.g., to explore "single winner" designs, or designs that combine Medicare and Medicaid networks.

CPAC therefore must have enough flexibility to experiment with different demonstration designs in rural areas. The BBA already gives CPAC broad waiver authority with respect to M+C provisions. But new legislative authority might be needed to work flexibly in resolving problems of, say, meshing M+C coverage with existing Medicaid networks or allowing the award of a single M+C contract in some counties. New legislative authority is definitely needed to waive the existing budget neutrality constraint that applies to the demonstration, since, in any event, new funds are likely to be required in any rural project outside an urban area.

6. CPAC and the AACs should continue to develop quality incentive arrangements.

At the time the Kansas City and Phoenix demonstrations were stopped, CPAC and the local AACs were developing ways to introduce quality incentives into the payment structure of the demonstration. This one demonstration cannot explore all of the possibilities for incorporating quality incentives in Medicare payments – that would be a separate demonstration – but the Competitive Pricing Demonstration can continue to explore and test new methods in this area. Without undue disruption, these new methods can reinforce existing Medicare quality initiatives and underscore the need for payment schemes to attend to the value of what is being purchased, not just the price.

7. The Competitive Pricing Demonstration should continue to be based on a standard benefit package. CPAC should continue to explore ways to moderate the effects of that constraint, in ways that do not undermine the competitive bidding process.

CPAC believes that, on balance, the competitive process should be based on a standard benefit package, that benefits should be set at levels that constitute the market norm for the demonstration areas, and that a minimum benefit should be established that includes some outpatient prescription drug coverage (\$500 in the current design). CPAC also

believes that it is important to continue to explore ways to moderate the costs of standardization (e.g., the Phoenix proposal that 1 percent of the bid be devoted to any additional benefit the plan chooses, thereby allowing some additional plan discretion in the overall package without undermining the bidding process). However, CPAC believes it important to avoid changes in the benefit package that promise to undermine competition at the bidding stage. Thus, the committee opposes allowing high-bidding plans to offer benefit reductions (e.g., a higher percentage of out-of-pocket costs) in return for a reduction of the out-of-pocket premium.